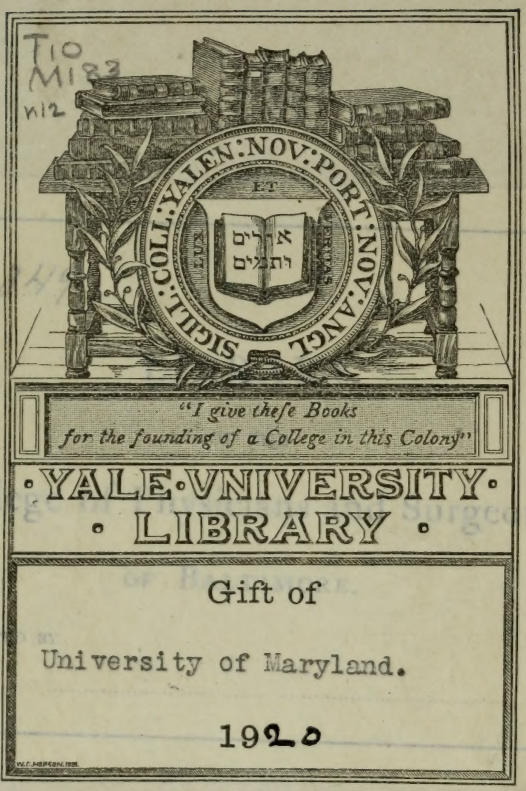
T10
M183
N12



TRANSFERRED TO
YALE MEDICAL LIBRARY
GENERAL MEDICAL LIBRARY

MARYLAND

1061
1/2 vol

MEDICAL JOURNAL,

A WEEKLY JOURNAL OF

MEDICINE AND SURGERY.

VOLUME XII.

NOVEMBER, 1884—MAY, 1885.

EDITED BY

THOMAS A. ASHBY, M. D. EUGENE F. CORDELL, M. D.

NEWBERRY A. S. KEYSER, M. D., ASSOCIATE EDITOR.

—PROPRIETOR—

T. A. ASHBY, M. D.

COLLEGE OF PHYSICIANS
LIBRARY
OF
AND SURGEONS, BALTO.

BALTIMORE:
JOURNAL PUBLISHING COMPANY PRINT,
No. 35 Park Avenue.
1885

Coll-MC
1-14-19

CONTRIBUTORS TO VOLUME XII.

Barton, J. M., . Philadelphia, Pa.
Berkley, H. J., . . Baltimore, Md.
Bochroch, M. H., . Philadelphia, Pa.
Bombaugh, C. C., . . Baltimore, Md.
Browne, B. Bernard, . Baltimore, Md.
Butler, J. C., . . . Belair, Md.
Chunn, W. P., . . Baltimore, Md.
Coleman, W. Franklin, . "
Coskery, Oscar J., . . "
Councilman, W. T., . "
Crandall, T. V., . Philadelphia, Pa.
Donaldson, Henry Herbert, Baltimore, Md.
Donnell, W. T., . . Devil's Lake, Dakota.
Dulles, Charles W., . Philadelphia, Pa.
Dunglison, Richard J., "
Forbes, Wm. S., . "
Genese, D., . . . Baltimore, Md.
Gosweiller, A. Van Hoff, . "
Harlan, Herbert, . . "
Harrison, J. Stinson, . Washington, D. C.
Hocking, J. W., . Govanstown, Md.
Hodgdon, Alex. L., . Farmwell, Va.
Hollopeter, W. C., . Philadelphia, Pa.
Homans, John, . . Boston, Mass.
Jones, Wm. J., . . Baltimore, Md.
Keating, John W., . Philadelphia, Pa.
Lassing, H., . . . New York, N. Y.
Lustgarten, Sigmund, . . Vienna.
Mackenzie, John N., . Baltimore, Md.
Marcy, Henry O., . . Boston, Mass.
McIntosh, W. Page, . Baltimore, Md.
McSherry, Richard, . . "
McSherry, H. Clinton, . "
Meierhof, E., . . . "
Michael, J. Edwin, . "
Morison, Robert B., . . "
Nancrede, C. B., . . Philadelphia, Pa.
Neale, L. E., . . . Baltimore, Md.
Oliver, Charles A.. . Philadelphia, Pa.
Payne, R. L., . . Lexington, N. C.
Pennington, J. I., . Baltimore, Md.
Platt, W. B., . . . Baltimore, Md.
Potsdamer, Joseph B., Philadelphia, Pa.
Roberts, John B., . . "
Rust, Geo. W., . . . Luray, Va.
Sutton, R. S., . . . Pittsburg, Pa.
Theobald, Samuel, . Baltimore, Md.
Uhler, J. R., . . . Baltimore, Md.
Webb, W. H., . . Philadelphia, Pa.
Willard, De Forest, . Philadelphia, Pa.
Wilson, Charles Meigs, . "
Wise, Edward M., . Baltimore, Md.
Woods, Hiram, . . Baltimore, Md.

T10
M183
v.12

349

INDEX TO VOLUME XII.

PAGE.

A Contemporary of Shakespeare..... 201
A Field for Statistical Investigation. *Ed*..... 280
Abdominal Section, Treatment of Acute Peritonitis by..... 467
Abdominal Sections, Mr. Lawson Tait's 100 Cases of, *Ed*..... 202
Abdominal Sections, Observations in 137, *Sutton*..... 17
Abdominal Surgery, Dr. Thos. Keith on Antiseptics in, *Ed*..... 344
Abdominal Surgery, Mr. Lawson Tait on the Best Anæsthetic for Use in, *Ed* 203
Albuminous Urine, Picric Acid as a Test for..... 146
Albuminuria, False..... 147
Albuminuria from Chloroform Inhalations..... 415
Alcohol in Relation to Voice Use; Influence of..... 408
Alcohol, Sir Andrew Clark on..... 187
Aloes..... 409
Alveloz, The Drug; Its Use in Cancer. 293
American Academy of Medicine, The 9, 25, 66
American Medical Association, The Annual Meeting of the, *Ed*..... 484
American Medical Association, Delegates Appointed from the Clinical Society of Maryland to, for 1885.... 497
Anæmia, Treatment for marked Idiopathic..... 370
Anæsthetics, Administration of. *Ed*. 165
" " 186
Anæsthetic in Labor, The Bromide of Ethyl as an..... 477
Anæsthetics in Obstetrical Practice.... 120
Animals, Self-Mutilation of, *Ed*..... 425
Announcement, Editorial..... 105
Annual Message of Mayor Latrobe. *Ed* 343
Antipyrin..... 184
Antiseptics, Portable..... 263
Antiseptic Solution, An Ophthalmic, 501
Antiseptic Surgery, Modern..... 30
Artium Magister..... 25
Ascarus Mystax; The Occurrence of, in the Human Body..... 150
Aspiration, Cases Suitable for..... 209
Asthma, The Treatment of..... 466
Astragalus, Excision of, for Caries..... 323
Auditory Canal, External, Case of Rapidly Returning Growth in the, *Woods*..... 456, 495

PAGE.

Bacilli, Comma..... 349
Bacillus, Comma, A Test of the..... 396
Bacilli, Tubercle, Suggestions upon the Relation Between the Diet and Growth of the, *Ed*..... 483
Bacillus of Syphilis. *Ed*..... 465
Bacillus of Syphilis, Another..... 384
Bacillus of Syphilis, The. *Lustgarten* 451
Bacillus, The Leprosy..... 449
Bacillus Tuberculosis, Dr. A. Flint on the Diagnostic Value of..... 248
Bacteria, The Rate of, in Infectious Diseases..... 22
Baltimore Medical College, Fourth Annual Commencement of the..... 429
Baltimore Polyclinic and Post-Graduate School, The Second Annual Announcement of, *Ed*..... 367
Barton, J. M..... 176
Bayview Asylum Management.. *Ed*. 426
Benzoate of Ammonia..... 463
Benzoin in Chaps and Frost Bites..... 189
Berkley, H. J..... 105
Biology, School of. *Ed*..... 404
Bladder, Irritable, Treatment of, in the Female..... 262
Bladder, A Simple Method of Washing Out the..... 370
Bladder, Papilloma of the..... 200
Bladder, Pepsin as a Solvent of Blood-Clots in the..... 442
Bladder, Tumor of (Enlarged Third Lobe of Prostate Gland)..... 219
Board of Examiners of Va., The. *Ed*. 183
Board of Health in Penna., Propects of a, *Ed*..... 226
Bochroch, M. H..... 16
Bombaugh, C. C..... 66
Brain, Excision of Tumor of..... 187
Brain, Lodgment of Breech-Pin in the, with Recovery..... 221
Brain, Removal of a Tumor From the 248
Brain, Specimen of a..... 157
Brain, The Ophthalmoscope in Diseases of the. *Coleman*..... 459
Brain Disease, The Use of the Ophthalmoscope in the Diagnosis of, *Coleman*..... 411
Bright's Disease of Malarial Origin... 96
Bright's Disease, Varieties of Dyspnœa in..... 125
Bromide of Potash, Its Influence on Nutrition..... 369

PAGE.

Bromidrosis of the Feet, Treatment of 485
Bronchitis, Dr. H. C. Wood on Treatment of..... 327
Browne, B. Bernard..... 11
Burns and Scalds, Chlorate of Potash for 249
Bursting of Kitchen Ranges, *Ed*..... 264
Butler, J. C..... 274
Cæsarian Section, Performed by a Patient herself..... 428
Calculi in the Female..... 322
Calculus Formed in the Sub-Lingual Gland, and Chalky Deposit in Wharton's Duct. *Wise*..... 455
Campbell, Prof. Henry, of Augusta, Ga. 8
Cancer, Alveloz Used in Treatment of 293
Cancer, Does Smoking Cause..... 468
Cancer of Liver, a Tumor caused by Retained Fæces mistaken for..... 209
Carbuncle, Compression of..... 288
Cardiac (?) Aneurism, A Case of..... 397
Cardiac Aspiration, A Plea for, etc.... 284
Caries of the Clavicle, Sternum and First Rib, in a Syphilitic Patient, who died of Tuberculosis..... 496
Catarrhal Diseases, Trephining the Frontal Sinuses for..... 406
Catarrh of Respiratory Passages, Treatment of..... 129
Cephalo-thoracopagus, Specimens of... 25
Chloral Hydrate, A Case of Poisoning from 30 grains of, *Potsdamer*..... 273
Chloride of Ammonium..... 125
Cholera, Asiatic, Treatment of.....127, 308
" Bacillus, Koch on the Power of Drugs to Arrest the Development of, *Ed*..... 66
Cholera Commission, of India, *Ed*..... 367
" Epidemic.....294, 342
" " in Italy..... 216
" " of 1884, The Characteristics of..... 285
Cholera Epidemic, The Origin of..... 369
" in Paris..... 65
" Precautions Against, in Factories..... 125
Cholera Precautions, *Ed*..... 485
Cholera, Report of English Commission 286
" Specific Directions for Preventing..... 69
Cholera, The Use of Water in Collapse of, *Harrison*..... 337
Cholera, Treatment of..... 405
Chordee, Chloral Hydrate for..... 466
Chunn, W. P..... 51
Clinical Notes from the Practice of *H. C. McSherry*..... 31

PAGE.

Clitoris, Great Hypertrophy of the..... 461
Cocaine, A Layman's View of..... 428
Cocaine, Action of the Muriate of, on the Temperature Nerves, *H. H, Donaldson*..... 475
Cocaine and the Opium Habit..... 488
Cocaine, Applied to the Vagina..... 284
" Caution in the Use of..... 208
" Hydrochlorate of...8, 80, 283, 303
" " of, Experience with the, *Uhler*..... 6
Cocaine, Hydrochlorate of, in Obstetrical and Gynecological Practice, *Ed*. 279
Cocaine, Hydrochlor. in the Otalgia Due to Catarrhal Inflammation of the Ear..... 469
Cocaine, Hydrochlorate of, Observations and Conclusions from the Use of, *Oliver*..... 135
Cocaine of Dermatology..... 408
Cocaine, in Dysphagia..... 207
" " Eye Surgery, Bad Results from..... 305
Cocaine in Genito-Urinary Procedures, 206
Cocaine, Its History and Use..... 181
" in Laryngeal Phthisis..... 125
" " Neuralgia..... 309
" Manufacture of, *Ed*..... 143
" Muriate of, Clinical Experience with the, *Theobald*..... 57
Cocaine, Muriate of, in Intense Pruritus, *Ed*..... 446
Cocaine, Muriate of, in Labor, *Uhler*., 20
" " " " Veneral Surgery, *Michael*..... 59
Cocaine, Muriate of, Its Use at the Presbyterian Eye, Ear and Throat Hospital of Baltimore..... 60
Cocaine, Oleate of..... 448
Cocaine, Used in Operating for Lupus Vulgaris..... 119
Coccygodynia, Diagnosis of..... 29
Cohnheim, Prof., A Monument to, *Ed*..... 87
Coleman, W. Franklin.....371, 411, 459
College of Physicians and Surgeons of Baltimore, The Thirteenth Annual Commencement of the..... 389
Color-Perception, A Correlation Theory of..... 229
Constipation, Forced Dilatation of the Anal Sphincters in the Cure of..... 300
Contagia, Tyndall on Living, *Ed*..... 386
Convallaria Majalis, Dr. E. T. Bruen on, 304
Convulsions, A Case of, followed by Death..... 341
Convulsions of Children, Chloral in the 468

PAGE.

Convulsions of Pregnant and Parturient Women, Venesection in..... 148
Corrected Statement, *Ed*..... 404
Corrosive Sublimate in Antiseptic Surgery, Sir Jos. Lister on..... 45
Coryza Vaso-Motoria (Hay Fever)..... 24
Coskery, Oscar J..... 391
Councilman, W. T.....74, 331
Crandall, T. V..... 32
Cranial Cavity, Report of Two Cases of Tumor within the, *Councilman*.. 331
Cranial Fracture, A Case of..... 302
Cremation..... 287
" and Burial..... 185
" The Progress of, *Ed*..... 263
Crime and Its Causes, *Gosweiller*..... 360
Croton Oil, A New Use for..... 284
Croup, *Crandall*..... 32
" Discussion on..... 38
Cutaneous Disease; Lesions of the Nervous System Etiologically Related to..... 408
Cyst, Parovarian, Removal of a, with Recovery..... 62
Cystitis, Chronic..... 218
" in the Female, *Johnson*...151, 158
" Pyelonephritis and Chronic Parenchymatous Nephritis in the same Patient, Complicating..... 324
Deafness, Veratrine in the Treatment of 189
Degeneration of City Life, *Ed*..... 484
Delirium Tremens, Chloral in..... 306
" " Treatment of..... 306
Dermentia Paralytica, Recovery of Case of, *Hocking*..... 71
Dermatitis Herpetiformis Caused by Nervous Shock..... 229
Dermatitis Herpetiformis, Its Relation to so-called Impetigo..... 29
Dermatology, Cocaine in..... 408
Diabetes Mellitus, Skim Milk in..... 208
" Frerichs in Treatment of..... 129
Diarrhœa, Monsel's Iron in..... 466
Diphtheria..... 428
" A Method to Secure Children Against Attacks of..... 279
Diphtheria, Abortive Treatment of, 29, 487
" Calomel in..... 369
Diphtheria of Fauces, Functional Disturbances of the Eyes, following..... 500
" Specimen from a Case of... 401
" Two Cases of, in one of which Tracheotomy was successfully performed..... 239
Diphtheria, Treatment of..... 287
" " " with Mercuric Chloride, *Fry*..... 94

PAGE.

Diphtheritic Conjunctivitis..... 241
Disturbance to Vision after Injury to the Cerebrum..... 122
Diuretic Mixture, A.....338, 369
Donaldson, H. H..... 475
Donnell, W. T..... 292
Dulles, C. W..... 251
Dunglison, R. J..... 211
Dysentery, Bismuth Injections in..... 349
" Chronic, Treated by Voluminous Enemata of Nitrate of Silver, 249
Dysmenorrhœa and Menorrhagia, Novel Remedies in..... 486
Dysmenorrhœa, Treatment of by Rapid Dilatation..... 89
Dystochia from Coiling of Umbilical Cord around Neck of Fœtus..... 249
Ear, Two Cases of Inflammation of the Middle..... 443
Educational Institutions, The True Way to Estimate Success in..... 429
Elephantiasis Arabum, Note on a Case of, *Morison*.....311, 381
Electric Mouth Lamp and Laryngoscope..... 115
Emetics..... 499
Epidemics, Temperature Peculiarities in, with Report of Seven Cases, *Hollopeter*..... 191
Epilepsy, A Contribution to Jacksonian, and the Situation of the Leg Centre..... 282
Epilepsy, Cure of by Trephining..... 347
Epithelioma of the Lip..... 384
Errata.....370, 470, 501
Erysipelas as a Complication of Pregnancy and Labor..... 309
Etherization, Management of Patients during..... 349
Examination of Applicants for License to Practice, A Means of Raising the Standard of Medical Education..... 21
Eye, A Method of Removing Foreign Bodies Embedded in, *Meierhof*..... 175
Eye, Foreign Bodies in.....145, 463
Fatty, Tumor, A..... 157
Favosa Gastritis; A New Disease..... 500
Fæcal Impaction, Case of..... 120
Females, Invalid, *Rust*..... 424
Female Patients Rudeness to, *Ed*..... 426
Femoral Neck, A Case of Possible Bony Union after Intra-Capsular Fracture of, *Roberts*..... 236
Femoral Neck, Discussion on union of, 237
Fistula, Recto-Vesical, in the Male.... 420
Forbes, Wm. S..... 171
For Sale by All Druggists, *Schæffer*... 318

PAGE.

Fracture, Compound, of Leg and Foot, with Amputation..... 220
Fracture of Skull..... 421
Fry, H. D..... 94
Genese, D..... ....274, 361, 362
Germ Theory, Influence of Future Therapeutics on..... 129
Germs; Chronological History of the Discovery of Disease..... 189
Glioma Retinæ, A Case of..... 29
Gonococcus of Neisser, The, *Ed*..... 6
Gonorrhœa and Chordee..... 149
Gonorrhœal Germ, The..... 65
" Rheumatism..... 144
Gosweiller, A. Von Hoff..... 360
Gout, Relation of Certain Diseases of the Eye to..... 247
Gout, Treatment of.....109, 369
Grant Case; A Running Commentary on the, *McSherry*..... 494
Gums, Lancing the, in Infants..... 223
Gun-shot Wounds of 3d Lumbar Vertebra and Aorta..... 302
Hæmatocele, Treatment of Retro-Uterine..... 168
Hæmorrhoids, Treatment of by Forced Digital Dilatation..... 187
Hair, Periodical Changes of Color of the 448
Hair, Restoration of Color, A Case of 147
Handle of Music-box Passing through the Alimentary Canal of a Child.... 97
Harlan, Herbert..... 318
Harrison, J. S..... 337
Harvey's Forecast of Great Modern Discoveries..... 45
Hay Fever Treated by Galvano-Cautery 300
Headache, Sick, Treatment of..... 329
Health, A New National Board of, Proposed..... 142
Health and Education..... 422
Heart Disease, Caffein in..... 409
Heart, Inorganic Murmurs, *Mitchell*... 131
" " " Discussion 162
" Presystolic " heard in a 241
" Rupture of..... 37
Hemiplegia, Double Infantile Spastic, 283
Hernia, A Radical Cure of by Torsion of Sac..... 146
Hernia, Double Inguinal in a Male Infant 38 days old, with Operation for Strangulation, *Steinbach*..... 133
Hernia, Notes on Some Instructive Cases of, *Roberts*..... 271
Hernia, Specimen of Internal with Valvulus..... 80
Hill, W. N..... 159
Hodgdon, Alex. S.....338, 475

PAGE.

Hocking, J. W..... 71
Homans, John..... 338
Homœopathic Medicine, Puck's Realistic Recipe for..... 249
Home for Incurables of Baltimore City, *Ed*..... 499

Hospital Reports:

Presbytian Eye, Ear and Throat Charity Hospital Reports....60, 222, 318, 456
Hospital Relief Association, of Md., Fourth Annual Report..... 105
Hospital Saturday and Sunday Association.....121, 181
Humerus, Subspinous Dislocation, Case of..... 98
Hydrocephalic Brain with Calvarium, 119
Hydrodimon as an Antipyretic..... 128
Hygiene of Beef, *Lassing*..... 12
Hyoscine, Dr. H. C. Wood on the Physiological and Therapeutic Effects of..... 308
Hysterical Difficulty in Breathing through the Nose..... 31
Hysteria, Simulating Locomotor Ataxia..... 120
Hystero-trachelorrhaphy, Observations from the Study of 142 Cases of, *Wilson*..... 1
Hypospadias, Simulating Hermaphrodism, A Case of, *Councilman*..... 174
Ideal Doctor, The..... 169
Infection, A Peculiar Case of..... 140
Infectious Diseases, What is the Explanation of Acquired Immunity from, 159
Influence of Nervous System on Rigor Mortis..... 122
Ingrowing Toenail, Carbolized Resin for, *Genese*..... 361
Ingrowing Toenail.....130, 306, 388
Insanity, Medical and Legal Definition of..... 140
Insanity, A Lecture on, *McSherry*..... 314
" Curability of..... 228
" Introspective..... 267
Intermittent Pulse..... 89
Intestinal Obstruction..... 347
" Occlusion..... 439
Intussusception, Treves on Treatment of..... 187
Iodoform Collodion..... 268
" Eruption..... 427
" in Erysipelas..... 284
Iron, Administration of..... 29
Jequirity; Dr. W. Cheatham on..... 349

PAGE.

Jequirity, Notes on, with Table of Cases, *Woods*..... 231, 299
Jequirity; Its Uses in Diseases of the Skin..... 89
Johnson, J. Taber..... 151
Johns Hopkins Hospital..... 306
Jones, W. J..... 291
Kairin as an Antipyretic..... 99
Keating, John M..... 351
Keratitis, Interstitial, in a Subject with Probable Hereditary Syphilis, *Oliver* 76
Kidney, Congenital Smallness of the Right, with Enormous Compensating Hypertrophy of the Left..... 462
Kidney, Fixation of Movable..... 126
" Malignant Disease of the, with Autopsy, *Bruen*..... 312
Koch, Dr., in his Laboratory..... 345
Labor Cases, Cleanliness in..... 469
" External Use of Chloroform in, 329
Lachrymal Gland, Adeno-Fibroma of.. 323
Lamb Prize Essays..... 317
Lancing Childrens' Gums..... 268
Laparotomy, A Year's Work in..... 392
" for Perforation of the Stomach and Intestines..... 405
Laparotomy, Foriegn Bodies in Abdomen after..... 26
Larynx, Excision of..... 343
" Pin in..... 31
Lassing, H..... 12
Law, Shall we have a, to Regulate the Practice of Medicine in Maryland, *Ed* 225
Laws Regulating the Practice of Medicine, *Dunglison* and *Mary*..... 211
Legal Control of Medical Practice by a State Examination, The, *Roberts*, 73
Legal Decision in W. Va., An Important..... 28
Legal Enforcement of Study at Home, The..... 28
Lens, Spontaneous Dislocation of..... 501
Liberating the Ring Finger in Musicians, etc., *Forbes*.....171, 178
Life Insurance, Weight as an Indication of the Character of Risks for, *Ed* 86
Life-saving from Drowning by Self-Inflation..... 348
Lister, Honor to Sir Joseph, *Ed*..... 326
Liver, Abscess of..... 479
" Specimen of Perforating Abscess of, *McIntosh*.....55, 79
Locomotor Ataxy, Althaus on..... 69
Lumbar Colotomy Performed in a Case of Imperforate Rectum..... 129
Lung, Abscess of, Cured by Incision and Drainage..... 69

PAGE.

Lungs, Congestion of, from Heart Failure..... 180
Lustgarten, Sigmund..... 451
Lymphatic Glands, Importance of Early Removal of Caseous..... 286
Mackenzie, John N..... 453
Malaria, Lemon Juice in..... 404
" Salicylate of Sodium in..... 206
Malarial Fever, A Contribution to the Pathology of..... 339
Malarial Fever, Hæmorrhagic; Treatment of..... 266
Marcy, Henry O..... 211
Martin, Prof. H. Newell, on the Zoophilist, *Ed*..... 498
McIntosh, W. Page..... 55
McSherry, Richard.....314, 334, 494
" H. Clinton..... 31
Medical Advice by Telephone..... 329
" and Chirurgical Faculty of Maryland, Annual Meeting of, *Ed*.. 385
Medical and Chirurgical Society of Maryland, Delegates Appointed from Clinical Society of Maryland, to, for 1885..... 496
Medical and Chirurgical Faculty, Special Meeting of, *Ed*..... 447
Medical Colleges; Their Relation to Preliminaay Education..... 21
Medical Congress, International; Ninth Session to be held at Washington, D. C., n 1887.....434, 446
Medical Economics from the Standpoint of the General Practitioner, *Hill*..... 154
Medical Education and Practice Abroad, *Platt*..... 85
Medical Education, State Medical Examining Boards and Endowment of Schools as Factors in the Elevation of the Standard of, *Ed*..... 103
Medical Examination, State, in N. C., *Ed*..... 104
Medical Examination, The Proposed State in N. Y., *Ed*..... 326
Medical Items, 10, 30, 50, 70, 90, 110, 130 150, 170, 189, 210, 229, 250, 269, 289 310, 329, 350, 370, 390, 410, 429, 450 470, 489, 502.
Medical Library, Boston, *Ed*..... 203
" Requirements, Higher, in Virginia, *Ed*..... 497
Medical Sickness, Annuity and Life Assurance Society of England, *Ed*., 304
Medical Status of Baltimore, The, *Ed*., 404
" " " English in the Soudan, *Ed*..... 387

PAGE.

Medical Student, Aged 74 years..... 488
" Students, Female, in Paris... 328
" " Valuable Suggestions to..... 27
Medical Teaching, The Reputation of Baltimore for, *Ed*..... 303
Medications, Intra-Uterine, Dr. L. Athill on..... 144
Medicines, Patent, The Druggists and, *Platt*..... 362
Medicus, Index, *Ed*..... 425
Meierhof, E..... 175
Mental Diseases, Acute, Intermediate Hospitals for the Treatment of..... 205
Michael, J. Edwin..... 59
Micrococci in Relation to Wounds, Abscesses and Septic Poisons, *Ed*... 108
Migraine..... 228
" Prophylaxis of..... 189
" Salicylate of Soda in the Treatment of..... 501
Miscarriage..... 375
" Management of..... 285
Mitchell, Chas. W..... 131
Monomania, Delusional, *Bochroch*..... 16
Morison, Robert B..... 311
Morphiæ Sulphas, An Instance of the Ingestion of 13 Grains of, followed by Recovery, *Hodgdon*..... 475
Nævus Pigmentosus, Two Cases of..... 322
Naucrede, C. B..... 111
Nasal Inflammation, Chronic; Classification of Stages Based upon the Anatomical Changes which the Nasal Erectile Tissue undergoes..... 383
Nasal Polypi and Asthma..... 31
Neale, L. E. 355
Needles, Introduction and Extraction of 147
Nephritis, Parenchymatous, which was accompanied by Intestinal Ulceration and Pelvic Abscess..... 441
Nephritis, Treatment of..... 247
Neuralgia, Cocaine in..... 309
" Its Cause and Cure, *Reyburn*..... 91
Nitrite of Amyl, Squibb on How to Use..... 123
Nitrite of Amyl, Squibb on Therapeutics of..... 123

OBITUARY.

Bird, Dr. Harvey L..... 106
Jay, Dr. Septimus D..... 328
McKew, Dr. D. J..... 306
Reed, Dr. James A..... 30

PAGE.

Wingfield, Dr. T. H..... 465
Obstetric Forceps, Use and Abuse of.. 228
Œsophagus, Impacted Mass in..... 31
Officers of the Baltimore Medical Association for 1885..... 229
Officers of the Medical and Surgical Society of Baltimore, for 1885..... 229
Official Position, Misuse of,..... 346
Oleates, Shoemaker on..... 109
Oliver, Charles A.....76, 135
Ophthalmia Neonatorum..... 29
" " Prevention of, 129
" Purulent, in Infants..... 486
Otorrhœa in Children, Remarks on.... 407
Ovarian Cysts..... 321
" Cyst, An..... 476
" " Papillomatous..... 394
" Tumor, An..... 137
" " The Sac of..... 99
Ovaries, Malignant Cystic Disease of, 138
Ovariotomy, A Report of Two Cases of, *Neale*.....355, 383
Ovariotomy, Antiseptics..... 109
" Double, with Unusual Complications..... 297
Ovariotomy, Points in..... 333
" Revival of, in England, *Ed*..... 164
Ovariotomy, Sponge Left in Abdomen after..... 329
Ovariotomy, Spray in, *Homans*..... 338
Paracentesis Thoracis as a Therapeutic Agent..... 126
Parturient, Quinine, etc., as a.....429, 487
Pasteur's Pets..... 188
Pathology and Clinical Medicine, The Proper Relations of..... 421
Patella, A Case of Dislocated, Without Rupture of Tendon, *Butler*..... 274
Patent Nostrums, The Duty of the Med. Profession in Respect to, *Ed*. 403
Payne, R. L.....338, 375
Payne's, Dr., Letter, *Ed*..... 345
" " Prof. Tiffany's Reply to an Open Letter by..... 389
Pelvic Cellulitis, Several Cases of..... 116
Pelvis, Fracture of, Cured..... 80
Pennington, J. I..... 431
Phimosis, Treatment of, Without Cutting Operation..... 288
Phthisis, Disinfecting the Sputa of..... 346
" Heart from a Case of..... 440
" Precautions to be Adopted in the Treatment of..... 501
Phthisis, Shall the Physician frankly tell the Consumptive Patient that the Disease is..... 469

PAGE.
Phthisis, Transmission of..... 184
" Treatment of the Sweating of..... 370
Physician, Dr. Flint's Model..... 128
" What is the True Function of, *Ed*..... 120
Physicians and their Female Patients, *Ed*..... 182
Physiological Effects of Light which Enters the Eye through the Sclerotic Coat..... 122
Placenta Previa, Combined Turning in Treatment of, *Ed*..... 163
Platt, W. B..... 85
Platt's Chlorides..... 489
Pneumonia..... 267
" A Peculiar Form of..... 226
" Acute Uncomplicated Labor; Its Etiology, Pathology and Treatment, *Pennington*..... 431
Pneumonia; Chaporis on the Resolving Action of Calomel in..... 68
Pneumonia; Does Quinine Abort it.... 305
" Infectious, Osler on..... 126
" Treatment of, by Cold Baths..... 169
Poisoning by Pennyroyal..... 99
" " Sardines..... 247
Poliomyelitis Anterior in Adults..... 207
" " with Report of Two Cases..... 199
Post-Graduate Instruction of the University of Maryland, *Ed*..... 366
Post-Mortem Specimens, Temporary Preservation of..... 169
Potsdamer, Joseph B..... 273
Pott's Fracture, Specimen of Excessive Deformity Produced in..... 98
Practice, Qualifications for..... 467
Pregnancy, Cervical..... 319
" Mural..... 347
" Treatment of Vomiting, Obstet. Society of London..... 209
Pregnant Women, Surgical Operations upon the..... 148
Prefuce Gratting.....126, 244
Presbyterian Eye, Ear and Throat Charity Hospital..... 9
Presystolic Murmur, Notes of a Case of, 291
Preston, Geo. J..... 114
Procidentia Uteri Treated by Shortening the Round Ligaments with Kæpho-Perineorraphy..... 43
Prostate Gland, Hypertrophy of..... 219
Pruritus, Ani..... 288
Pruritus, Cocaine in, *Ed*..... 446

PAGE.
Pruritus Vulvæ; Pixene in the Treatment of..... 369
Psoriasis; Verruca, Epithelioma, a Sequence..... 308
Publications, New, *Ed*..... 166
Puerperal Convulsions, A Case of..... 262
" Eclampsia..... 481
" " Etiology and Prophylaxis of..... 346
Puerperal Fever, Measures to Arrest the Origin and Spread of, *Ed*..... 464
Puerperal Septicæmia..... 458
Pulmonary Congestion, Note on a Peculiar Form of, etc.,..... 284
Pulmonary Consumption, The Treatment of..... 427
Pulmonary, Intra-, Injections..... 265
Pyloric Stenosis, Measures Devised for the Relief of..... 460
Quackery in Baltimore, *Genese*..... 362
" in Maryland, The Necessity of Concerted Action to Suppress it, *Ed*, 366
Quackery in this State, Shall an Effort be made to Suppress, *Ed*..... 325
Quinine, on the Blood, Action of..... 305
" The Hypodermic Administion of..... 37
Rabbeth Memorial, The, *Ed*..... 87
Rectum, Bone in the..... 422
" Stricture of the; A Short Note on Two Cases of, *Coskery*, 391, 494
Rectus Femoris, Rupture of the..... 98
Regeneration of the Vagus and Hypoglossal Nerves, Observations on..... 307
Remedy for Street-Noises, A..... 368
Resection of the Pyloris for Carcinoma, A Case of..... 146
Resection of the Spinal Column, *Ed*.. 140
Resignation of the Secretary, State Board of Health of W. Va., *Ed*.... 345
Respiration Cavernous, Dr. A. Flint on 348

REVIEWS.

A Manual of Nervous Diseases; an Introduction to Medical Electricity, *A. B. Arnold*..... 326
A Manual of Organic Materia Medica, *John M. Maish*..... 282
A System of Practical Medicine, *Wm. Pepper*..... 281
A Text-Book of Hygiene, *Geo. H. Rohé*..... 265
Diseases of the Nose, *Clinton Wagner*, 107
" of the Œsophagus, Nose and and Naso-Pharynx, *Morell Mackenzie*..... 46

PAGE

Henke's Atlas of Surgical Anatomy, *W. A. Rothacker*..... 143
Insanity and Allied Neuroses, *Geo. H. Savage*..... 282
Manual of Chemistry, *Simon* 67
" of Dermatology, *Robinson*... 68
On a New Method of Recording the Motions of the Soft Palate, *Harrison Allen*..... 122
Principles and Practice of Gynecology, *Emmet*..... 226
Pyuria, or Pus in the Urine and Its Treatment, *Robert Ultzman*..... 167
Surgical Delusions and Follies, *John B. Roberts*..... 281
The Elements of Physiological and Pathological Chemistry, *T. C. Charles* 204
The Lock-Jaw of Infants (Trismus Nascentium), *J. F. Hartigan*..... 88
Reyburn, Robt..... 91
Rheumatism, Oil of Wintergreen in... 407
Rhinitis, Catarrhal, Salvia Officinalis (Sage Tea) in,..... 409
Rhinitis Sympathetica, *Mackenzie*, 453, 495
Ringworn, Lee on..... 288
Roberts, John B.....73, 236, 271
Rötheln, A Contribution to the Clinical Study of..... 146
"Rough on Rats," Specimen of Stomach from Case of Poisoning by, *Willard*..... 333
Rudimentary Fingers and Toes..... 97
Rust, Geo. W..... 424
Salicylic Acid in Lupus Vulgaris..... 201
Sarcoma, An Obscure Case of Popliteal Aneurism Simulating..... 283
Sarcoma, An Alveolar, of the Kidney, 278
" of Rectro-Peritoneal Glands, 399
" Spindled-celled, of Breast.... 243
" of Clavicle..... 277
" of Skin..... 219
Scalp Wounds, Treatment of..... 387
Scarlet Fever, Carbonate of Ammonia in..... 442
Scarlet Fever in Pregnancy..... 188
Schaeffer, E. M..... 318
Scrofulous Neck..... 406
Seven Springs Iron-Alum Mass..... 269
Sewer-Gas Poison, Diseases Produced by, *Ed*..... 263
Sleeplessness..... 449

Society Reports.

American Academy of Medicine, Ninth Annual Meeting..... 21
Baltimore Medical Association.....119, 130, 180, 262, 341, 375, 422

PAGE

Clinical Society of Maryland....24, 42, 79, 96, 116, 159, 199, 239, 299, 339, 381, 420, 459, 494
Medical Society of the District of Columbia...36, 81, 99, 156, 293, 363, 376, 416, 443, 458, 479
Pathological Society of Philadelphia. 216, 277, 322, 397, 439
Philadelphia Clinical Society.....274, 288
Philadelphia County Medical Society. 38, 178, 196, 237, 258
Philadelphia Obstetrical Society....62, 137, 296, 319, 392, 476
Washington Obstetrical and Gynecological Society..... 29
Specialties and their Relation to the Medical Profession..... 285
Spleen, A Diminutive..... 201
Spleen, A Rupture of the..... 36
Stammering, The Treatmeut of..... 283
Steinbach, L. W..... 133
Steiner's, Dr., Election as Librarian to Enoch Pratt Free Library, *Ed*... 86
Stomach, Operative Dilatation of the Orifices of the..... 424
Stomach, Ulcer of..... 274
Stomach-Tube, Death from Introduction of..... 50
Strictures, Electrolytic Treatment of... 388
Suggestions Applicable to the Season, *Ed*..... 224
Sulphide of Carbon, Disintection by the Fumes of..... 349
Superfœtation, A Possible Case of..... 180
Suppurative Arihritis; Its Conservative Treatment, *Nancrede*..... 111
Surgery of General Practice, Suggestions from Dispensary Experience, *Dulles* 251, 258
Surgical Scarlet Fever, *Ed*..... 183
Sutton, R. S..... 17
Sweating, Excessive..... 368
Syphilis Excession of the Initial Sclerosis 124
Syphilis, Mercurial Injections in..... 128
Syphilitic Disease of the Nasal Pharynx 388
Tabes Dorsalis, Spasmodic, *Keating*... 351
Tape-Worm, Areca Nut in the Treatment of, *Genese*..... 274
Tape-Worm, Chloroform a Dangerous Remedy for..... 29
Tape-Worm, On the Treatment of.... 49
Terpine..... 189
Thallin, Another Antipyretic..... 209
Theobald, Samuel..... 57
Therapeutic Gazette, *Ed*..... 463
" Progress, *Ed*..... 244

PAGE.

Tobacco, Does it Produce Amblyopia? *Coleman*..... 371
Tongue, Unilateral Spasm of the..... 324
Tracheotomy 34
" A Note on 450
" for Diphtheria to Render Oral Suction Harmless After..... 223
Tracheotomy, The Larynx, Trachea and Bronchial Tubes from a Patient on which it had Been Performed... 495
Transfusion Apparatus, A Portable... 448
Trousseau was Miserable, Why..... 327
Tubercle-Bacillus, Sir Andrew Clark on the, *Ed*..... 498
Tubercle, Its Transmissibility by Vaccination 305
Tubercular Disease; Specimen of Kidney, Bladder and Testicle..... 80
Tubercular Meningitis Treated with Free Phosphorus..... 289
Tuberculosis, Acute Miliary, Two Cases of, *Preston*..... 114
Tuberculosis, Facts Serving to Prove the Contagiousness of; with Results of Experiments with Germ-traps Used on Detecting Tubercle-Bacilli in the Air of Places of Public Resort, etc., *Webb*.....471, 491
Tuberculosis, Injection of Powdered Material into Abdominal Cavity of Rabbits Does not Induce..... 208
Tuberculosis, Iodoform in the Treatment of..... 149
Tuberculosis, Transmissibility of, by Vaccine Lymph..... 489
Tuberculosis, Three Cases of..... 216
" Ulcerated Vermiform Appendix, Supposed Cause..... 375
Typhoid Fever, Ergot in..... 328
" " Inverse Type of Temperature in, *Hollopeter*.....191, 196
Typhoid Fever, Mild Cases of.....363, 377
" " Specimens of Typical Lesions of.....376, 379
Typhoid Fever, Symptomatic Treatment of..... 346
Uhler, J. R.,.....6, 20
Ulcer of Leg, A French Treatment for 188
Umbilical Cord, Treatment of the..... 368
University of Maryland, The 78th Annual Commencement of the..... 409
Urine, A New Test for Bile Acids in the 466
Urine, A New Method for Collection of, *Ed*..... 204
Urine, A Test for Albumen in the..... 409

PAGE.

Urine, Incontinence of..... 285
Uterus, A Hæmorrhagic..... 37
Uterus, Anteflexion of the, and its Treatment..... 186
Uterus and Ovaries, Removal of, for Fibro-Myomata, *Burton*..... 176
Uterus and Vagina, A Double..... 296
Uterus, Cancer of.....37, 81
Uterus, Excision of, for Cancer..... 248
Uterus, Fibroid Tumor of, with Sessile Attachment to the Fundus, Removal by Enucleation, *Browne*..... 11
Uterus, Hair-pin in the..... 64
Uterus, Gangrenous Fibroid Tumor of the 393
Uterus, Perforation of the Bowel from Bimanual Examination of the..... 387
Uterus, Perforation of the, by the Sound with Report of Cases, *Chunn*.....51, 118
Uterus, Post-Partum Avulsion of, with Recovery..... 127
Uterus, Ruptured..... 319
Uterus, Tuberculosis of the..... 44
Uteri, Unicorn and Bicorn..... 242
Uterine Appendages, Removal of, for Menstrual Epilepsy, with Recovery. 62
Uterine Displacements, Shortening the Round Ligament for..... 405
Uterine Hæmorrhage, The Injection of Hot or Cold Water in..... 499
Urethra, Female, Recent Progress in the Diagnosis and Treatment of the Diseases of the, *Ed*..... 245
Urethral Polypi..... 323
Vaccination, A Hairy..... 402
Vaccine Vesicles, The After-Treatment of... 429
Vaginal Speculum, A Demonstrating. 188
Varicocele..... 416
Variola, Potassium Iodide Rash Simulating..... 486
Vienna, Letter from, *Berkley*..... 105
Voice, The Care of the..... 136
Volume, Close of..... 10
Vivisection in Great Britain, *Ed*..... 463
Vivisectionists, Anti-; Prof. Martin and the, *Ed*..... 385
Webb, W. H..... .....471, 491
Whiskey and Wine in Toxæmic Conditions, *Donnell*..... 292
Whooping Cough and Resorcin..... 149
Willard, De Forest..... 333
Wilson, Charles Meigs..... 9
Wise, Edward M 455
Women, Use of Drugs in Nursing..... 467
" Vigor of American..... 287
Woods, Hiram.....231, 456

LIBRARY
AND SURGEON'S, CAL TO.

Original Articles.

OBSERVATIONS FROM THE STUDY OF 142 CASES OF HYSTERO-TRACHELORRHAPHY. *

BY CHARLES MEIGS WILSON, M. D., OF PHILADELPHIA.

Though much has been written on this subject in the past few years, I trust a description of special instruments, and a summary of the histories of 142 cases will not be amiss. In view of the exhaustive treatment the subject has received in the hands of many observers, I hesitate to report my own limited experience. One hundred and four of these cases occurred in the practice of Dr. E. Wilson, two in my own, and the balance I witnessed as assistant either in hospital or private practice. I regret that circumstances prevented me from obtaining a full history in all the cases. No one should hesitate performing the operation or be unable to recognize the lesion. Yet very frequently gynecologists have sent to them either for an opinion or operation cases diagnosed as eroding ulcers, fungoid vegetations, cancer, etc., which, when the patient is properly examined, prove to be cases of laceration. The touch alone is sufficient to establish the existence of the lesion. If corroborative evidence be required the patient should be placed in the knee-chest position, and the uterus exposed with a Sims's speculum. For in this position, if each everted lip be grasped with a tenaculum by gentle manipulation the natural contour of the cervix can be restored. If this simple feat can be accomplished, the diagnosis is at once established; for in malignant disease, ulcerations of the os, etc., this cannot be done. Reeves Jackson considers this test infallible. Formerly many cases of laceration were comprehended under the generic term ulcer. But the description of the lesion, and the operation by Dr. Emmet has settled forever the well-worn controversy which so long divided medical opinion concerning the etiology and pathology of the so-called ulceration of the cervix uteri. Oftentimes useless and injurious applications are made to the cervix, because the gentlemen having the medical care of the cases do not understand that the cervix is torn. The old-fashioned tubular speculum is still too frequently used. It is now generally conceded that it is useless except where "harsh" treatment is to be applied to the cervix without injury to the vagina. The tubular speculum separates the already everted lips and makes the laceration assume a more angry appearance. Thus faulty methods of examination often obscure the diagnosis. Another difficulty with many physicians is, that the symptoms of which the patient complains are too apt to be regarded as the expression of some malady in which the uterus is not involved; unless, indeed, they complain of some vaginal discharge (a condition rarely observed). Again, the train of symptoms which belong to laceration belong equally to many other uterine ailments, and nothing but a carefully conducted examination can demonstrate that such is the case. The anæmia, debility and other results of laceration, like the results of many other pathological conditions of the pelvic viscera, are often treated by a course of tonics, whilst the underlying causes of all the mischief goes on with its destructive work. When a woman consults a physician, complaining of any of the more marked symptoms, such as cranial, rectal, vesical or pelvic pain, a feeling of weight about the uterus, disordered menstruation, and leucorrhœal discharge, a vaginal examination should be considered an "imperative and essential prerequisite to treatment." The best of investigators is always at hand, namely, the index-finger, which, says one of the masters of genecic surgery, "when properly educated and used to the full extent of its capability, there is hardly any of the pathological conditions of the pelvic organs in woman which can escape its detective powers." Simpson, in England, and Gardner, in this country, first called attention to lacerations of the cervix. Emmet, as he himself says in his book, accidentally discovered the lesions in 1862 and devised the operation for its relief. To him belongs the credit of revolutionizing gynecic surgery. Parturition is the chief cause of the lesion. The pressure of the child's head alone, especially if it be a large one, upon the os, may even in a normal labor be sufficient to lacerate it. If the os be rigid, or as frequently happens, be both rigid and attenuated, the

* Read before the Obstetrical Society of Philadelphia, and taken from the report of the meeting held Oct. 2nd, 1884.

danger is of course increased. If the longitudinal and oblique fibres of the uterus have greater contractile force than the circular fibres of the lower segment of the uterus have expansive power, the force of the contractions of the former exerted upon the fœtal body, which rests upon and is engaged with the latter, may lacerate them owing to their non-expansion. In premature labor, the circular fibres of the os not being ready for the dilatation necessary to permit the egress of the contents of the uterus may give way, i. e., there may be sufficient irritation of the uterus to expel its contents by contracting the fundus, but not enough to expand the os. Meddlesome midwifery is a prime cause. By which term I mean the practice of trying to force back from the presenting portion of the child the margin of the os, without waiting for it to dilate properly; the desire to expedite the labor in every possible way, the premature rupture of the membranes —the physician forgetting that nature's dilator, the "bag of waters," is the best of all. Experience teaches that all labors in which the membranes have been ruptured prematurely, either accidently or purposely, are apt to be complicated by some laceration of the obstetric canal, especially of the cervix. Unnecessary and unscientific application of the forceps, and traction made with them without a proper knowledge of the pelvic canal and outlet is another factor. That the forceps are responsible for many cases of laceration there can be no doubt. When applied high up or within the uterus they are exceedingly apt to produce tearing of the cervix. Observations made by Dr. Mundé at the Mt. Sinai Hospital, New York, showed 119 cases of laceration in 700 women examined. Dr. Hanks, of the Demilt Hospital, found only eight per cent. troubled with laceration. The Mt. Sinai is a private institution and most of its patients Hebrews. These are generally attended by midwives. The Demilt is patronized by the poor of the city generally, and the patients are mostly attended by young graduates who frequently use the forceps. As far as these observations go, they show that the forceps, even in inexperienced hands, do not do as much to produce laceration as the often untimely interference of ignorant midwives. Prof. Gross, in one of the last papers he ever wrote, spoke of the frequency with which the forceps were applied, strongly condemning this practice and very justly attributing many of the cases of laceration of the cervix to it. He formulated his views in the words, "The principle causes of laceration are precipitate labor, labor attended with rigidity of of the mouth of the womb and instrumental labor." Dr. Fundenberg, in an article which appeared in the *Pittsburg Medical Journal*, makes use of this positive language: "I believe that the forceps, when properly applied, is a prevention of laceration of the cervix. * * * * When carefully introduced, for instance, to a rigid os, dilated only sufficiently to receive a narrow blade, the waters being discharged, it preserves the cervix by its inclined plane, from sudden impulse, and imitating the bag of waters in its wedge-like and outward action, it dilates with great and continuous power, with any desirable amount of slowness, and with very great safety" In the 142 cases seen by the writer, the forceps had been used in 49, presumably from the account of the patients, at the labor from which their distress dated. Did space permit, I should like to quote from other papers in reference to this question. Suffice it to say that the maladroit use of the forceps is responsible for many cases of laceration. The breech presentation is another factor, because of the necessity of rapidly delivering the head. The cervix may also be torn by the shoulders after the head has passed safely through. The injurious practice of giving large and frequent doses of ergot prior to the expulsion of the fœtus is another cause; so, too, are abortions. The predisposing causes include the various forms of induration, whether caused by hyperplastic deposit or malignant disease, all affections of the cervix producing tissue softening, such as epithelioma, or any condition interfering with the natural elasticity of the part, as the cicatrices of previous surgical procedures, or as happened in two of the cases the writer saw of cauterizations, and any syphilitic or strumous taint giving the uterus lack of tone. Dr. E. Wilson lays great stress on the muscular depravity, the result of a constitutional syphilitic taint, and the consequent emaciated condition of os. This muscular degeneration may be the result of many pathological conditions. For example, anæmia, malnutrition, phthisis and the like. Again, when the uterus is in a state of constant

activity, owing to frequent gestation, it is liable to lose tone, and thus pave the way for the exciting cause to light up the trouble. Women are more apt to meet with this accident at the time of their first delivery than subsequently. It occurs also more frequently in rapid labors. Dr. Emmet believes that partial laceration takes place at the first delivery. Dr. Goodell, Dr. Pallen and Dr. Mundé all record it as being exceedingly common. In two hundred women with uterine disease examined by the writer, 19 had laceration of the cervix. The lacerations may extend through any portion of either lip. The writer has found the bilateral to be the most common—the rent being greater upon the left side—and laceration through the posterior lip the rarest form. The fact that a laceration has taken place is seldom noticed at the time of its occurrence.

When an examination is made at the completion of the delivery, the parts are so enlarged, soft and yielding, and the os so patulous that it is difficult to detect a laceration. But if a tear has occurred the woman soon begins to complain of symptoms which are well-nigh pathognomonic. Shortly after she rises from her bed and resumes her ordinary household duties she notices a more or less constant and generally increasing leucorrhœal discharge. This discharge is thick, viscid and glairy, and sometimes tinged with blood. Sometimes, though rarely, this discharge is absent, or after a time disappears. Pain is a prominent symptom. It is generally of a dull and aching character. It is frequently referred to the lumbar region. Headache is a marked symptom. There is a peculiar sense of weight about the uterus which is increased, along with the pain, after exertion. This feeling is augmented when the woman assumes the erect posture. The menstrual flow is, as a rule, increased. It is profuse, longer in duration and comes on after shorter intervals. There is generally a nasty, glairy, and sometimes semi-purulent discharge during the catamenial intermission. My own observation has taught me that there is generally an increase in duration and amount. When the laceration is recent, the increase is so small that it is hardly noticed; but, as a rule, it increases steadily until it sometimes assumes the character of a sudden and violent uterine hæmorrhage. Patients generally suffer with a feeling of malaise. The general health soon becomes impaired. The digestive system is often the first to suffer. Sexual appetite is usually impaired, sometimes abolished; its gratification being always attended with great pain. Insomnia is often present, together with other symptoms of a nervous character. The writer has seen one case in which hystero-epilepsy was a prominent symptom. The symptoms are usually commensurate with the extent of the eversion of the lining membrane of of the cervical canal. This membrane, when thus exposed, loses its delicate epithelial coat, and it chafes against the posterior wall of the vagina. This irritates and inflames the raw surfaces. Hypostatic congestion and engorgement ensue. This prevents proper involution of the uterus, and the parts remain enlarged and soft. The heavy uterus, inadequately sustained by its supports, falls to the floor of the pelvis, dragging the upper portion of the vagina with it. This makes the cervix look elongated, when in reality it is shortened. Sometimes cicatrization takes place, and often this plug of cicatrical tissue gives rise to symptoms more distressing than when the parts remain ununited. The mental symptoms are sometimes very grave, amounting to such a degree of mental perturbation as to threaten the sanity of the patient. One of Dr. E. Wilson's patients was for some months in an insane asylum. After her cervix was restored, her symptoms gradually subsided, and eventually, in the space of six weeks, entirely disappeared. This woman was deprived of her liberty because her friends refused to have the operation done. Another woman in his practice, a subject of melancholia with uterine symptoms, came very near being spayed. After her cervix was repaired, her melancholia and other symptoms vanished entirely. A very curious case of persistent salivation, apparently due to laceration, at all events which was cured by restoring the cervix, is reported by Dr. Longyear, in Vol. xvi, No. 1, of the *American Journal of Obstetrics*. Did space permit I might cite other interesting cases.

If the foregoing views in reference to laceration are correct, the indications for treatment are certainly clear. Having decided to resort to surgical means for the relief of his patient, the surgeon must consider whether the patient is in a proper

state of health to be operated on. The same conditions which militate against other surgical procedures are equally operative in cases of trachelorrhaphy. When the uterus is bound down by adhesion, or severe inflammation exists, it is dangerous to operate. One patient who came under my observation nearly perished from an attack of peritonitis, because forcible traction was made to draw down to the ostium vaginæ a uterus which was fixed and immobile, owing to adhesions, the result of a former attack of peritonitis. For operating, the patient should be placed in the dorsal posture, with her buttocks well drawn down to the edge of the table, an assistant taking charge of each limb. The cervix is exposed with a Sims's speculum, grasped with a volsellum,and gently brought to the ostium vaginæ. The needle having an appropriate curve is passed through the cervix in the median line, from above downward; it is then armed with a stout piece of silk cord and withdrawn. A blunt-pointed tenaculum is then passed up the cervical canal until it engages the cord, a loop of which is withdrawn. This loop is divided, and the two free ends are united, thus forming two loops, the one controlling the anterior, the other the posterior lip. The margins of the tear are now freshened, care being taken to extend the line of incision beyond the angle of the rent, and to cut out any cicatricial tissue that may be present.

The hæmorrhage, which is never very profuse, and which, by depleting the vessels of the uterus, tends to ameliorate the inflammatory conditions often present, is easily controlled by the application of hot sponges. Any one who has seen many operations must have noticed the sudden blanching and softening of the cervix, due to the bleeding attending the operation. The late Prof. Gross thought that the benefit of the operation was largely due to this local depletion. I have seen the circumflex artery cut on several occasions, but it never required a ligature to control it. Care should be taken to make the posterior angle of the plug of tissue removed sufficiently acute to allow of the proper approximation of the lips without tension on the sutures. The lower lip should be denuded first, otherwise the hæmorrhage will obscure the field. Sufficient mucous membrane should be preserved in the centre to reform the canal. This is not always possible, and when it cannot be done, a small piece of carbolized lint should be inserted to prevent union in the line of the canal. This should be removed at the end of twenty-four hours, otherwise the canal may be occluded. This accident happened in three of the cases of Dr. E. Wilson's series, and the occlusion was overcome with some difficulty. All clots having been removed, and exact hæmostasis having been maintained for some moments, the wound is closed by inserting a needle through both lips, arming it with a wire suture, withdrawing it, freeing the wire, and clamping it with a shot. The ends are then cut off close to the shot. The suture should be removed by the tenth day. (Dr. Wilson then exhibited some scissors devised for that purpose). The vagina should be syringed twice daily with a solution of the mercuric bichloride (1 to 2000). A Sims's speculum should be used to remove the stitches, as there is danger of tearing the freshly united surfaces apart with a bivalve. In three cases I have seen excessive bleeding, all occurring on the third day after the operation. This, however, did not seem to come from the wound, but was regarded as the result of a passive congestion of the endometrium. If the operation is successful, the relief afforded is speedy and sure, and, what is more, generally permanent. The operation is simple and free from danger. It often renders sterile women capable of child-bearing.

Dr. E. Wilson has attended in confinement ten women on whom he had previously performed the operation. In two there was a slight recurrence of the tear. In many cases where coitus was impossible, on account of the pain and hæmorrhage it produced, the difficulty has been entirely overcome. In one case only did the operator fail to get a satisfactory result. The cervix was badly torn. It was repaired. The woman was afterwards found to have salpingitis. Though her health improved after the restoration of the cervix, she did not recover. In a future communication to the Society I hope to show her Fallopian tubes. Allowed to run its course, the sequelæ of lacerations are end ess—disturbances of the catamenia, dyspareunia, oöphoritis, leucorrhœa, subinvolution, grave mental disturbances, and, above all, epithelioma. In conclusion, gen-

tlemen, permit me to quote the words of a distinguished gynæcologist: "These are no longer the chimeras and hobbies of the specialist, but grave and serious dangers." It is to be hoped that in time to come a more scientific and certain knowledge of the dangers and difficulties of parturition, and of the means for their avoidance, may enable physicians to avert the accident.

DISCUSSION.

Dr. Baer inquired if the operations were done for the relief of sterility.

Dr. Wilson replied that they were for the relief of general symptoms. Ten of Dr. Ellwood Wilson's patients had since become pregnant.

Dr. Goodell remarked that he had no trouble in removing the stitches. His method was to leave the two lateral upper stitches with long-shotted ends; by means of these each side of the cervix could be drawn into the field of his bivalve speculum and the stitches removed with ease.

Dr. Montgomery bore testimony to the same, and to the value of the bivalve speculum over Sims's for that purpose. He had used the double thread through the cervix, and had described its uses before this Society at the meeting of October 6th, 1881, as published in full in the "Obstetric Gazette" for January, 1882. As regarded the quantity of tissue to be removed in closing a laceration, the operator must be governed by the character of the injury, and it might not be possible to have a satisfactory result where there was an anteversion of the uterus, the flexion occurring in the lower part of the cervix, the anterior lip being elongated and hypertrophied, the posterior normal or even atrophied; for in such cases it was impossible to prevent the preponderance of tissue in the enlarged lip. He could readily understand that, such a uterus becoming gravid, in the subsequent labor the long anterior lip would form a segment over the child's head, which would almost certainly result in laceration. In the case which Dr. Wilson cites of extensive laceration during labor, the proper treatment would have been to perform a primary operation by the immediate introduction of sutures, rather than permit the patient to be subjected to the necessity of a secondary operation. It would be necessary to introduce the sutures much deeper, and then to make allowance for the subsequent involution. It was not infrequent that multiple lacerations resembled epitheliomatous disease, and were accompanied by an offensive discharge. He had given temporary relief in such a case by the use of chromic acid and tannin locally. The needle used in passing the suture should not be much larger than the wire that is to follow it.

Dr. Wilson questioned the propriety of primary operations on the cervix, and thought the weight of authority against it.

Dr. Montgomery remarked that the first case by Montrose Pallen was a primary operation, and was successful.

Dr. Chas. H. Thomas remarked that at the meeting of this Society, held October 6, 1881, he had reported a case of laceration of the cervix uteri simulating cauliflower excresence, which he had treated eighteen years before. The patient was exsanguine from hæmorrhage, which had put her life in great danger. He used glycerole of tannin tampons, and at the end of two weeks she had improved immensely, and the condition finally proved to be a deep laceration with ectropion. Before the treatment she had been seen by six experienced gynæcologists, who declared the condition cancerous, and one of them refused to be convinced that it was not so, saying, within the last four years, that "it had been cancer, it was cancer, and she would die of cancer." When the case was reported, another of the physicians who had originally seen the case, inquired of Dr. Thomas if he "proposed to cure uterine cancer by means of glycerole of tannin tampons." The menopause has since been established, the uterus, examined within the past month, was found atrophied, and the former patient has been for nearly twenty years a hard-working monthly nurse.

Dr. Goodell thought it pardonable to make the mistake. With all his experience he had seen two cases in which he could not for some time make a certain diagnosis. There was no doubt about the existence of a laceration, but whether the angry-looking growths were merely cock's-comb granulations or epithelioma was not so easy to decide. They eventually proved to be benign.

EXPERIENCES WITH HYDROCHLORATE OF COCOAINE.

BY J. R. UHLER, M. D.

(*Read before Baltimore Academy Medicine Oct.* 21, 1884.)

Immediately after the publication of the experience of Drs. Agnew and Noyes with hydrochlorate of cocoaine, I obtained some of the drug and tried it in three per cent. solution on the following cases:

1st. *Acute Catarrh.* A few drops were introduced by the finger and camel's hair pencil into the nasal cavity at intervals of five minutes and at the end of 15 or 20 minutes considerable relief was experienced accompanied with a certain amount of anæsthesia.

Case 2nd. Some of the same solution was gently rubbed into herpes of the upper lip producing numbness resembling that of tinct. of aconite but unaccompanied with any burning sensation. At the end of twelve minutes superficial pinching produced no pain but the deeper parts of the lip retained normal sensibility.

Case 3rd. Inflamed, protruding hemorrhoids were bathed, at intervals of five minutes, with a little of the solution and at the end of twenty minutes could be handled without producing pain.

Case 4th. Three or four drops were rubbed by the finger at five minute intervals upon the mucous membrane of the mouth, around a tooth that was about to be extracted, producing anæsthesia of the gum, but not causing any effect upon the deep seated pain as the tooth was drawn from its socket.

Case 5th. A hard, painful corn was bathed with some of the same solution but owing to the thickness of the tissue no appreciable effect was produced.

Case 6th. A painful scirrhus of the breast (with skin unbroken) was bathed with drops of the solution for 15 minutes, but no appreciable effect seemed to ensue.

From the above, it would appear, that hydrochlorate of cocoaine will be of very great service to mitigate, or entirely stop pain in mucous membranes or where small operations have to be performed, but from the superficiality of its action is not suitable where skin or deep structures have to be extensively destroyed. The class of cases in which it will prove most useful are irritations of the eye, throat, nose, mouth, vagina, rectum and uterus, and for examinations during labor as well as in its last stages, and for vaginismus and prurigo, it will be invaluable.

Editorial.

The "Gonococcus" of Neisser.—The germ theory of disease has advanced rapidly throughout the last decade towards its establishment as a scientific truth. As a working hypothesis based upon chemical observation it has rendered infectious diseases intensely interesting, especially to the scientific ranks of the profession as opening up a broad field for investigation and research. Great has been the results of this research. Among the laurels won by medical science during the nineteenth century, the triumphs of the microscopist in his search for truth along the pathway indicated by the germ theory have been brilliant in the extreme, and we all entertain the hope that success may not stop here, but that the near future may also have great things in store, yet to be revealed to us. But, while the graver forms of infectious disease are being considered with regard to the germ and its workings, let us not forget that *all* infectious diseases must be investigated; and it behooves us, therefore, to regard attentively such investigations with reference to gonorrhœa, which have been carried on by numerous workers since the announcement made by Neisser, of Breslau, in 1879, of the discovery of a microörganism peculiar to and causative of gonorrhœa:—the *gonococcus*, which, as he afterwards claimed, was both physiologically and morphologically different from all other micrococci.

It was with pleasure, therefore, that we read in the *Philadelphia Medical News* of October 18th, the latest communication on this subject by Dr. G. M. Sternberg, U. S. Army, who is at present working in the laboratory of the Johns Hopkins University. This writer calls attention to the fact that the gonococcus has been fully demonstrated as being uniformly present in the pus of specific urethritis, unassociated with other microörganisms, and thus there are strong indications that it possesses some specific connection with the etiology of the disease. He refers to his previous work on

the subject published in January, 1882, when he denied that the gonococcus possessed distinctive morphological properties by which it could always be recognized from all other microörganisms; and, furthermore, from the failure of his inoculation experiments with the twentieth culture he denied positively its etiological relation to the disease, as accorded to it by Neisser and others.

Since that time Bockhart has successfully inoculated the urethra of a paralytic with a fourth culture of the gonococcus, producing as a result typical gonorrhœa. Dr. Sternberg is of the opinion that the fourth culture is not sufficient to exclude the original material from the inoculating fluid; and, granting that the fourth culture will produce a viruluent inflammation, while the tenth or twentieth prove innocuous, it must be admitted that the pathogenic power of the micrococcus in the first instance does not depend upon constant and inherent physiological characters, but upon special conditions relating to its environment. He admits the possibility that we here may have an example of a microörganism which may acquire and lose specific pathogenic power as the result of the circumstances of its surroundings, and, therefore, that the infective virulence of the disease in question may be due to the gonococcus. Furthermore, the experiments of Bockhart and Welander, when considered with the evidence relating to other infectious diseases, render this very probable, notwithstanding the harmlessness of the pure cultures; but Dr. Sternberg believes that a view more in concordance with the observed facts is, that this microörganism is widely distributed and is usually harmless, but that it may take on specific pathogenic power as the result of special conditions of environment and may again lose this power when removed from the influence of these special conditions. He then goes on to cite as proving that the special pathogenic power is not a permanent physiological characteristic of the gonococcus, three recent cases of inoculation with the ninth culture; both fluid and surface cultures being employed.

Dr. Sternberg, Dr. Keirle, of the College of Physicians and Surgeons of this city, and a medical student, submitted themselves to inoculation. Plegets of cotton imbued with the cultures were inserted into the urethræ and allowed to remain two hours, urination being restrained for as long after their removal as was possible. The results were negative, although the investigator repeated the experiment upon himself, using a No. 11 surface culture. Some days after he examined the mucus secretions from his meatus and found adhering to the epithelium cells numbers of micrococci resembling in every respect those of the culture fluid, thus proving the lodgement of the micrococci without the production of a urethritis. It is to be regretted that the number of subjects for inoculation should have been so limited. The healthy mucous membrane at times shows a strong resistance to disease, and if a large number of inoculations could be made and a negative result obtained, the evidence would be much more conclusive. But, unfortunately, unselfish lovers of science are not numerous when personal risks of discomfort and disease are called for, and the path of the investigator proves a difficult one.

As showing the wide distribution of micrococci morphologically similar to those in question, Dr. Sternberg refers to a plate in his admirable book, "*Bacteria*," where there is shown micrococci from the culture of the human saliva which cannot be distinguished from those of gonorrhœal pus. Dr. Councilman, the Pathologist at Johns Hopkins University, has observed the same similarity in micrococci obtained from the pus of post-mortem pustules on his own hands as well as from that of acute abscesses, as observed by Ogsten.

Opportunity offering, the pus from an acute abscess was made by Dr. S., the basis of a culture fluid, and the microörganism obtained, resembled, both in form and grouping, those from the culture of gonorrhœal pus. As regards size, they were slightly larger; but it is a noteworthy fact that these lower plants, resembling those of higher order may be changed morphologically by a modification of their surroundings and conditions of life. So the gonococcus of Neisser has deen observed to vary somewhat in size in different cultures.

"I believe," says Dr. Sternberg, "that the law of heredity, in conjunction with the various modifying influences to which these minute plants are subject in different situations, must tend to the establishment

of varieties and finally of species. But I do not find that the gonococcus of Neisser possesses any morphological peculiarities by which it can be distinguished from micrococci from other sources."

The Muriate of Cocaine.—This new anæsthetic which has attracted such marked attention in Northern cities has come into use in Baltimore, and has been employed by several surgeons. Dr. Julian J. Chisolm's experiments with this wonderful local anæsthetic, at the Presbyterian Eye and Ear Charity Hospital, confirm the experiences of the New York surgeons as regards its value in annulling temporarily the sensation of mucous surfaces; also proving the bland nature of an aqueous solution as strong as four per cent.

The first hospital case upon which it was used was that of a female suffering from a perforating ulcer of the cornea, with a degree of photophobia so intense that she could not stand any light whatever. The pain in the eye was constant and severe. In this case the experiment was tried to determine whether the cocaine solution could subdue morbid sensibility, as it had mastered the normal sense of feeling. A few drops of the four per cent. solution (twice as strong as ordinarily used, a two per cent. solution being the usual experimental liquid) were placed on this intensely inflamed eye. There was no immediate increase of suffering, a proof that the solution was *non-irritating*. Three instillations were made at five minutes' interval. At the end of fifteen minutes the eye could be boldly opened; pain had disappeared, and this hypersensitive surface, with its ulcer near the upper edge of the cornea through which a piece of iris was protruding, could be handled without discomfort. This case is a more positive evidence of the wonderful local anæsthetic action of the cocaine than when it is applied to a healthy surface to benumb the part, preparatory to operations.

The second case upon which the muriate of cocaine was tried was that of a mechanic, who, the day before, had been cut in the eye with a piece of iron. The wound extended through half of the cornea and into the ciliary region involving the iris and the lens. The eye had become very much injected, lens cloudy, and the patient, who was very nervous, was very demonstrative in his suffering. The history of the case was that of a wound received in chipping iron. How large or small the fragment was which caused the injury could not be ascertained. It was very important to determine whether the metalic fragment was in the eye or not. The patient's suffering and want of self-control excluded any possibility of probing the wound without the use of an anæsthetic. Resort was had to the cocaine solution, a few drops of which was instilled into the eye at intervals of three minutes. In the course of fifteen minutes the conjunctiva was seized with a forceps, without pain; the eye was drawn downwards so as to expose the entire wound, and the magnetic needle was introduced through the corneal wound across the anterior chamber and into the lens substance with the hope of attracting the metallic fragment if it be in the eye. This manipulation, which was painless, could not have been done if the decided anæsthetic effect of the cocaine had not been exerted.

These, with similar experiments, both upon the healthy and diseased conjunctiva, seem to show that in the muriate of cocaine we have discovered a remedy which can control the local sensation of this very sensitive surface to a wonderful degree. Experiments have also been tried upon other than conjunctival membranes. In the nose, the mouth, the urethra, the rectum, its application seems to be equally effective. If the cocaine will stop the agony of anal fissure, quiet the sensitiveness of a strictured urethra, stop the pains of distension of the uterine os in labor, allow teeth to be pulled without disturbance to the sufferer, permit growths from the ear or nose to be removed without pain, as well as make superficial operations upon the eye painless, then we may truly place this new discovery among the most wonderful of the 19th century, and one rich in blessings to suffering humanity.

Prof. Henry Campbell, of Augusta, Ga.—The medical profession throughout the United States is to be congratulated upon the successful operation recently performed upon the eyes of the President of the American Medical Association. For some time past the many friends of Dr. Campbell have been painfully aware of his failing sight. At the last meeting of the National Medical Association, at Washington, D. C., in May last, this blindness had progressed so rapidly

that he got about with much difficulty. Surgeons in Boston and New York pronounced the case one of cataract, to be remedied only by operation. In September Prof. Henry Campbell came to Baltimore. As the cataract had now matured, he placed himself in the hands of Dr. Chisolm for surgical treatment. Under chloroform a very successful cataract extraction was performed. The treatment was painless throughout, convalescence seemingly commencing with the operation itself. When the eye became strong enough to stand the light it was found that perfect vision had been regained, so that fine print could be readily read. In three weeks from the day of operation Prof. Campbell felt himself so completely restored to perfect vision that he left Baltimore for New York to attend a meeting of the Medical Council, having in charge preparations for the next meeting of the International Medical Congress, which will assemble in this country. We have since learned that Prof. Campbell has resumed the active and onerous duties of professional life with his pristine vigor. The medical professiou throughout the land will hail with great satisfaction the perfect results of this brilliant operation upon the eyes of their honored President. We in Baltimore are quite pleased that this restoration of sight should have been given by one of our own surgeons, especially as all the leading specialists of the great cities would have considered it a privilege to have been called upon to do this good work for this distinguished member of our profession.

The American Academy of Medicine which held its sessions in this city, on Tuesday and Wednesday of the present week, was a successful meeting in every respect. The attendance of Fellows was good, and the numerous papers and discussions which engaged the attention of the sessions testify to the fact that this organization is a live and cultivated body of scientific men. The objects of the Academy are such as to commend it to the thoughtful and cultivated members of our profession.

It is seeking to do a good work for the profession; that is to stimulate a collegiate training upon the part of all students who propose entering the medical schools of our country. This is a condition of things much to be desired. It is well-known that the average medical student is very deficient in his preliminary training for the great work he undertakes to do. The Academy does not pretend to say that a collegiate training is essential to the success of the practitioner of medicine, but it says that a thorough preparation for professional work is a long step in advance in the achievement of success in that work after it has been entered upon. It is well-known that some of the most brilliant men in the medical profession have never enjoyed the benefits of any but the plainest educational advantages prior to entering upon the study of medicine. Such men are exceptions, and it may be claimed for them that they would have achieved distinction under any circumstances. It can not be denied that every man is profited by educational advantages, and this certainly holds true of those men who enter the ranks of the professions. It is eminently proper then that the young men of our country, who have in view the medical profession, should be encouraged to prepare for this work by a thorough course in college. The standard erected by the Academy as a test of fitness for membership does not seem to be altogether just. The A. M. and A. B. degrees no more indicate the status of the scholar than the M. D. degree does that of the physician.

Degrees may be obtained in many ways and mean something or nothing according to the circumstances under which they were acquired. It seems necessary, however, that the Academy should have a standard of some kind, and we are not disposed to break down the one it has erected, although it does not seem to us to be in thorough accord with the real purposes it has in view. We fully realize the importance of such an organization and commend its objects and its work to the good will of the profession at large. Such members of the profession, as are eligible to Fellowship under its rules should cast their influence with the organization. Owing to our crowded space in the present issue we are forced to omit from our columns the proceedings of the meeting. We shall have more to say of this work in subsequent numbers of the Journal.

The Presbyterian Eye, Ear and Throat Charity Hospital is now out of the hands of the builders and is being furnished, preparatory to the public opening two

weeks hence. We in Baltimore now possess one of the largest and one of finest special hospitals in the United States, fitted up with every convenience for the comfort of anyone who needs hospital treatment for the restoration of sight. In the handsomely furnished rooms of this hospital all the comfort of the very best hotel can be obtained; and in the ample wards will be found everything needful for the comfort of those who are not blessed with the abundance of this world's goods and who yet are as anxious to obtain a restoration to sight as the wealthy, who may be affected with blindness. The new hospital building is a very handsome one, and reflects great credit on those who have had the erection of the hospital under care.

Close of Volume.—The increase in the number of pages now entering into a yearly volume makes it advisable to return to the method first adopted by this Journal of running two volumes for one year. Accordingly, volume XI closed with our last issue, and volume XII begins with the present number. We present the index for volume XI with this issue. The index to volume X, delayed by unavoidable causes, is now ready and will be mailed to any subscriber who desires it.

With the present issue the entire business and editorial responsibility involved in the conduct of this Journal reverts to Dr. T. A. Ashby. All communications relating to the Journal must be addressed to him.

Medical Items.

Dr. Wm. S. Forbes, the Demonstrator of Anatomy at the Jefferson Medical College, Philadelphia, was recently prosecuted for alleged violation of the cemetery acts of the State of Pennsylvania. After an expensive trial, he was triumphantly acquitted. The College rendered him no assistance, but the profession of Philadelphia took up the matter and raised $1,500, which has been turned over to Dr. Forbes to assist in defraying the expenses of the trial.=Prof. H. Von Zeissel, the distinguished sypilidologist, died in Vienna on the 23rd of Sept., at the age of sixty-seven years.=The two cases operated on at the Bellevue Hospital, New York, by Mr. Lawson Tait, for the removal of the uterine appendages, have recovered.=The College of Physicians and Surgeons, of New York, so recently endowed by the gift of $500,000 from Mr. W. H. Vanderbilt, has purchased a block of ground directly opposite the grounds of the Roosevelt Hospital, bound by Ninth and Tenth Avenues and Fifty-ninth and Sixtieth streets.=The Massachusetts General Hospital has recently received a gift of $10,000 from the late Francis P. Hurd, of Wakefield, Mass.=Dr. Louis A. Dugas, who died in Augusta, Ga., Oct. 19th, graduated from the University of Maryland in 1827. He practiced his profession successfully in Augusta for many years and occupied many high positions of trust and honor, being at one time President of the Georgia State Medical Society, and one of the Vice-Presidents of the American Medical Association in 1876 He was the editor of the *Southern Medical and Surgical Journal* from 1851 to 1858.=Muriate of cocaine is the rage just at present. Each one of the *Medical Weeklies*, with one or two exceptions, for the week ending Oct. 25th, had a contribution relating to the anæsthetic properties of this drug. Present experience claims a great deal for it. A double cataract was successfully performed at Mount Sinai Hospital last week, the muriate of cocaine being used. The patient experienced no pain.=An attempt is being made in Boston to organize a society for psychical research, *i. e*, for the study of mind-reading, spiritualism, mesmerism, etc. It may not be generally known that a similar society exists in N. Y. city, under the modest title of "The Academy of Anthropology."=Two-thirds of the obstetrical cases reported in Buffalo, N. Y., are said by Dr. Pryor to be attended by midwives.=At the meeting of the American Academy of Medicine, held in Hopkins Hall, Johns Hopkins University, on October 28th, forty-one physicians, from various States, were elected to the Fellowship of the Academy. Among the number of elected Fellows were Drs. H. P. C. Wilson and T. Barton Brune, of this city. =A bronze bust of the late J. Marion Sims, M. D., has been presented by his son, Dr. H. Marion Sims, to the New York Academy of Medicine. It was cast in Paris from the marble bust made a few few years ago by the eminent French sculptor, DuBois. =Dr. Oliver Wendell Holmes has come back to Boston from his sojourn at Beberly Farms, and will sit as autocrat in his city mansion.

Clinical Lecture.

ON A CASE OF FIBROID TUMOR OF THE UTERUS WITH SESSILE ATTACHMENT TO THE FUNDUS REMOVED BY ENUCLEATION.

(*Delivered at the Woman's and Child's Hosp., Oct.* 31, 1884)

BY B. BERNARD BROWNE, M. D.,

Professor of Gynecology in the Woman's Medical College of Baltimore; Professor of Gynecology and Obstetrics in the Baltimore Polyclinic and Post-Graduate Medical School, etc., etc.

This patient, M. F., age 32 years, colored and unmarried, has never had a child or miscarriage; she commenced to menstruate at 15 years of age and enjoyed perfectly good health until about two years ago, when, during her menstrual period, she strained herself in lifting some heavy furniture, and felt something give way inside of her; the flow continued very free for a month, during which time she remained at her work, but the hemorrhage became so profuse that she was obliged to go to bed, remaining there there six weeks, at the end of which time it had somewhat diminished.

From the time of the injury, however, she has suffered almost constant pain in the pelvis, and her menses, which had previously been regular and free from pain began to cause her great suffering, and for most of the time she has had both menorrhagia and metorrhagia. About a month after the injury she noticed a lump in the right inguinal region which she attributed to the strain. This lump, as you now observe, is quite prominent.

Two months ago she was obliged again to leave her place, where she was employed as chamber-maid and take to her bed. For the past month she has had a very profuse and offensive discharge from the vagina, the odor from which resembles very much that which you will find in the rooms of patients suffering from uterine cancer.

When I introduce my finger into the vagina it comes in contact with a large ulcerating mass resembling to the touch epithelioma of the cervix. I can, however, reach the anterior lip of the uterus, and can make out the protrusion of this tumor through the cervix; upon passing a sound I find the cavity of the uterus measures 3½ inches. I also find that the tissues around the uterus are not affected by any secondary inflammatory deposits, and that the uterus is forced or propped up out of the pelvis by the tumor, and that the lump in her side is really the fundus of the uterus thus forced out of the pelvis.

In this case we have very strongly pronounced symptoms of epithelioma:—hemorrhage, pain, foul-smelling discharge, general emaciation and dirty yellow tint of the skin, indicative of profound alteration in the properties of the blood and of impaired nutrition; to the sense of touch also, as I have said, it resembles very much uterine cancer, and was well calculated to mislead her former attendant into the belief that it was this disease.

In this case the differential diagnosis of fibroid tumor is based upon the following facts:

1. Fibroid tumors are exceedingly common in the colored race and cancer is equally as rare.

2. Epithelioma of the cervix very rarely, if ever occurs in women who have never been pregnant.

3. Cancer rarely begins at so early an age as 30, (the time at which the first symptoms appeared).

4. The uterus is never elevated out of the pelvis by epithelioma, but on the contrary is generally lower than normal.

5. In fibroid tumors the uterine cavity is frequently increased in length, whereas in epithelioma it is generally diminished.

6. Secondary inflammatory deposits in the surrounding tissues occur almost constantly in epithelioma, rarely in fibroids.

7. In epithelioma the tumor is never felt protruding into and through the cervix and distinct from the cervical tissue as in this case.

There are several methods by which this tumor may be removed, three of which I will mention:

1. Cutting away with scissors, and removing it in pieces.

2. Surrounding the pedicle with the écraseur, and, after cutting through the pedicle, removing the tumor by traction.

3. By enucleation.

The last, enucleation, is the method I will adopt. The patient having been placed under ether and in the Sims' position, gradual traction is made upon the tumor by large vulsella forceps; while one pair holds the tumor down as far as possible, another pair is placed above, the pedicle of

the tumor is thus put firmly on the stretch. Thomas' serrated scoop, is now passed behind the tumor up to the fundus and by gradual leverage with a sawing motion the pedicle is *separated at its point of attachment to the uterus*, and no fragment of the pedicle is left behind as you will observe by examining the tumor which will now be shown you. Although there was an apparent pedicle previous to the operation it has retracted into, and is part of the tumor; and the broad base of attachment to the fundus is more than three inches in diameter.

If the écraseur had been used it might have divided the pedicle and left a portion of the tumor in the uterus, or it might have drawn within its grasp a portion of the fundus and thus cut out a slice of the uterus (this accident is most apt to happen where the tumor has a sessile attachment as in this case); whereas by the plan of enucleation the uterine attachment of the tumor is completely separated and no portion of it is left behind.

Upon introducing, now, my finger into the uterus I find it completely empty—there is very little hemorrhage—the uterus and vagina will now be thoroughly washed out with hot carbolized water and the patient put to bed.

Original Articles.

THE HYGIENE OF BEEF.

BY H. LASSING, M. D., OF NEW YORK CITY.

A writer in a foreign magazine accounts for the longevity of the Israelite by ascribing it to the observance of the Mosaic and Rabbinical laws relative to marriage, the relations of the sexes, the hygiene of married life, and their strict dietary regulations. These latter were evidently designed for the maintenance of their health and strength and the protection of their bodies against disease. Thus we find included among the prohibited sources of food all carnivorous animals, the rodents, the carnivorous and corrion-eating birds, reptiles, amphibia and mollusca; a list comprising a complete group of beasts, such as the swine, the mouse, the rat, the cat and the dog, etc., known to be perfect foci of trichinal and other parasites. The communicability to man of parasitic diseases from animals used as food has long been placed beyond all doubt, it having been established that the parasite is simply transferred from the flesh of the beast to that of the man, in which it develops with frequently fatal results. The explanation of the reason for the prohibition of scaleless fish, such as the eel, only recently made by the scientists bears out this theory. It is that owing to the absence of scales the eel becomes a positive absorbent of noxious gases more particularly the noxious effluvia of decomposing and therefore poisonous matter.

These dietary laws are not confined to a mere division of all animals into two classes, the "clean and unclean." They prescribe even how much of the bodies of permitted animals may be consumed as food. Thus the use of blood is emphatically and repeatedly forbidden. This prohibition, and the importance evidently attached to it, harmonize so exactly with the lessons of modern science that it is impossible to regard them as motivated by any consideration other than the public health.

The possibility of the blood containing disease germs not immediately affecting the quality of the flesh, is not the only circumstance tending to disqualify it for food.

The blood, in its normal condition, almost invariably contains noxious elements. From the very nature of the double office of the circulatory system this must be so, for while, on the one hand, the blood serves to renew the various parts of the system after their ordinary wear and tear, on the other, it has to carry off the natural waste of the tissues. This waste or refuse is ultimately eliminated by means of the kidneys, the sudoriferous glands, etc., and then appears in its avowed character of excrementitious matter; but it must always be, to a certain extent, present in the blood, and in the event of any derangement of the action of the kidneys, accumulates in considerable and highly poisonous quantities. It must, therefore, be evident that the blood is always an undesirable article of food, especially as it is impossible when an animal is slaughtered to separate the arterial from the venous blood, which would be the only means of overcoming the difficulty.

"We contend," says one writer, "that to use the blood as food approximates very closely to drinking urine, and is not merely loathsome, but *pro tanto*, unsafe. That, like liquid and solid excrement, it is valu-

able for plant food, and that it serves as pabulum for certain classes of animals, is no proof that it is fit for human consumption."

The old Jewish Rabbins well knew the importance of this, some seventeen hundred years ago, when they recommended that in slaughtering animals, in addition to severing the trachea and œsophagus, the blood should be poured out from the vessels of the neck, and this at a time when it was believed the arteries contained only air.

One of the most important features of the Jewish system was an elaborate examination of the carcass before it could be declared fit for Jewish food; this examination prescribed by the Rabbins and faithfully carried out at the present day, is of an extremely vigorous and subtle nature, and completes the system by which the selection of animal food is governed. The conditions on which alone the flesh of animals is permitted to be eaten are singularly minute, and these laws carried out in their integrity, render the consumption of meat affected with specific maladies practically impossible. The lung is specially ordered to be examined and tested so that pleuro-pneumonia, tuberculosis, bronchitis and pulmonary maladies generally have little chance of escaping detection. "The extreme care of these early students of physiology, the Rabbins," says Dr. Maurice Davis, "in their examination of the lungs seem to point to the dicta of modern science which indicate the air passages, with their moist mucous membranes, as highly probable inlets of the morbid particles floating in the atmosphere." Dr. Behrend tells us that the animal diseases transmissible to man through ingested meat are seven in number, viz: cattle plague, swine typhoid, pleuro-pneumonia, foot and mouth diseases, anthracoid diseases, erysipelas and tuberculosis. By the observance of Jewish dietary laws it is impossible for animals affected by any of these diseases to be eaten. On the other hand, under non-Jewish systems, these diseases are broadcast with criminal recklessness. Dr. Carpenter stated some time ago in the *British Medical Journal* that an inspector of the Metropolitan Meat Market in London had declared, upon oath, that 80 per cent. of the meat sent to the London market had tubercular disease; and a letter addressed by a Mr. Jenkins to the *Times* a few months ago, calculated in reference to this same fact, that "at least 375,000 of the inhabitants of London annually run the risk of being tainted with consumption and of transmitting it to their unborn children." What wonder then that tuberculosis has so many victims?

One of the most important considerations for the physician is the quality and character of the diet of his patient, as well as of the community in which he lives. The most valued of articles of human food is beef. It was a favorite aphorism of one of our learned professors that beefsteak is the best tonic. This to a very large extent is true, and, therefore, all things being equal, it must be of vital interest to the physician to have the supply of beef of the very best and to have it in that condition which will furnish the greatest amount of healthy nutrition in the most suitable form, palatable and at a comparatively low price.

To speak on this matter intelligently, it is necessary first to consider what are the characteristics of good beef, what should be avoided and what required in its production.

Good beef, then, should be bright red in appearance, the muscular parts firm and elastic, the fat hard and light yellow or white; it should be free from all substances calculated to expedite putrifaction, such as exuded blood, bruises or extreneous dirt. To produce such beef it follows that the animal from which it is taken must be in a perfectly healthy condition and of the proper age when slaughtered, and that the process of slaughtering and preparing for market must be conducted in such a way as to obviate anything tending to vary from the conditions just enumerated.

Certain conditions may be enumerated which invariably tend to produce poor, unhealthy, as well as unsavory beef, while others just as surely will result in good, healthy and appetizing meat. No one can deny that long driving and exhausting railroad journeys in crowded cattle cars with insufficient food and water, the animals goaded, beaten and bruised by brutal drivers, frightened by unusual noises, will cause an inflammatory, congested condition of the meat and can never result in good wholesome beef. Again, the careless handling of the dressed meat, filth and dirt allowed to accumulate about the meat in the slaughter-house, insufficient emptying of the blood from the carcass,

all injure the quality of the beef.

And yet another consideration; which is that beef should be long enough killed before it is cooked to have allowed of complete relaxation of the muscular contraction of the fibre, without permitting even the slightest decomposition to take place. We must not for a moment lose sight of the fact that any process of decomposition may be arrested by antiseptics, yet can never be undone; or, in other words, the destructive work can never be so remedied as if it had not taken place.

It is clear, then, that healthy animals of a proper age, well rested, fed and watered, killed in such a manner as to produce the least fright and congestion, dressed in the cleanest possible manner, completely deprived of the excessive blood and animal heat, and so kept as to prevent even the slightest decomposition, will furnish the best, most wholesome and appetizing beef.

The last consideration is the availability of such good beef to the largest number of people. The nearer to the point of production and the more direct a product is bought from the producer the cheaper it must be.

Having thus spoken of the characteristic requisites and cost of wholesome, well-tasting beef, we will now briefly consider if such can be found within our reach.

In Chicago, one thousand miles nearer the vast cattle producing pastures of the far West, are the largest stock yards in the world. Connected with the entire Union by the most extensive system of railways centreing here, cattle are brought here from all directions, but more largely from the vast ranches of Montana, Colorado, Nebraska and Texas; and after being fully rested, fed and watered, are picked out and bought by a vast army of buyers for local use, as well as for re-shipment. The principal grades of cattle here represented may be divided for our purpose into home-raised and range cattle, and it may be stated that the quality of these latter has been vastly improved during the last few years, not only by a more careful breeding, but principally from the fact that so many railroads are now operated through the country that it no longer pays to drive these range cattle on foot only for the shortest distance to the nearest railway station.

The cattle having thus been carefully selected and purchased are driven to the cattle-pens of the different slaughter and packing houses which surround the stock yards and form a very large suburb of Chicago.

To give a correct idea of what seems the best method of slaughtering and dressing animals for the supply of wholesome, good beef for the Eastern markets we will now enter one of these establishments and follow a steer from the pen to the market in Boston, New York, Liverpool or London.

One of the largest of these beef-dressing places located on the edge of the stock-yards is that of the Swift Brothers, whose name on refrigerator cars and large refrigerators in the Eastern markets has become so familiar.

The other is that of Armour & Co. These are the two firms who are what are known as Chicago beef dressers. It may be added here that beef-dressing simply means the preparation of beef after killing, by cleansing it of all uneatable debris and offal, and not as some intelligent people even have imagined the application to the meat of any preservative mixture or wash.

The bullock to be killed is driven from the enclosure, wherein he is confined, to a separate pen and thence into a narrow stall where he is alone. Here he is stunned by one or two blows upon the head, which has a double object, one to disable him, but the more important object is to drive all the blood possible to the brain and forward parts. After this a chain is fastened to him and through a sliding-door he is hauled upon what is called the bed of the slaughter-house. Overhead throughout the entire building is a system of iron tracks, intersecting and connected by switches, to which are attached sheaves and blocks with hooks, and these being connected with powerful steam machinery may be run in any direction. After the steer is thus placed upon the bed his fore feet are so placed as to open as wide as possible the opening which is to be made in his arteries, and thus make sure of the perfect and entire exit of blood. He is again knocked in the forehead until his muscles relax when a man opens with a sharp knife one of the largest arteries in the body at the lower throat; his head is then entirely severed from the body, and by means of a chain on the hind legs he is hoisted up clear of the floor and is shoved into another place to make room for a fresh victim; he is again lowered on the floor, where he is placed on his back,

his feet taken off, the skin taken off the belly and sides, the breast and crotch sawed open and the caul taken off. This cau surrounding the stomach contains the pures fat in the steer and is washed and cleansed to be converted into the finest and most valuable suet oil. At this stage, the examination of the lungs is made, and if any evidence of disease is found the carcass is prepared for other uses than refrigerating, as it has already been shown that such meat will not keep. Thus in the self-interest of these Chicago beef-dressers lies the greatest safety of the consumer of this kind of beef. The carcass is then wiped all over, washed free from all blood stains and other impurities, it is then hooked and hoisted up part way; the tail is cut out, furnishing ample material for the celebrated ox-tail soup; the rump is skinned, and after being hoisted clear of the floor, two men beat down the fell on the hind legs, another takes the hide off the back, the entrils are removed and the animal is sawn down the spine from the tail, the back is thoroughly washed off and wiped and split down the middle; he is then hoisted further and run on a track to more thoroughly drain out the blood, the hide is entirely cut off from fore-legs and neck,the last attachment, and this is done in such a neat, careful way with clean knives and hands that the hides from this establishment bring an extra price in the market. The neck is split and the carcass is trimmed, carefully cutting off all ragged pieces of fat or meat, all blood stains or bruises. It is again thoroughly washed in two waters and wiped dry, when it is allowed to hang at the back of the beds near the cooler, where, after being allowed to thoroughly drip some fifteen minutes or more, it is again wiped and trimmed and shoved in the cooler to be entirely deprived of its remaining animal heat. It will thus be seen that the carcass is not only kept very clean, thoroughly emptied of blood, being about one hour or more in transit from the pen to the cooler, but none of the meat is ever, under any circumstance, allowed to touch the floor. The number of men actually handling the animal from the pen to the cooler is forty-two. In addition to these there are large numbers carrying away offal, washing floors and posts, wiping the hooks and implements; so that at the close of each day's killing there is not any filthy debris, or even blood left on the floor. While it is unavoidable for those who do the bloodiest work to keep from soiling their hands and clothing, they are by the strictest discipline, compelled constantly to wash their bodies, and the clothing is changed and washed at every resting spell. All debris is instantly removed and worked up to some useful purpose, so that there can be nothing remaining to cause any foul smell or decomposition; and in the various buildings on the grounds, though every process of manufacture of the debris is carried on, no smell of an objectionable nature is perceptible and cleanliness is carried to such an extent that a lady with kid gloves could fearlessly handle the woodwork of the coolers and the meat therein contained without soil or stain. The floors of these coolers are covered with clean, dry sawdust which is changed every other day. These coolers or refrigerators are very simple in construction with hollow walls, having an ice-chamber overhead, the cold air from which is conducted downward, and thus is kept up a constant circulation of pure air at an even temperature of about 40° F. These refrigerators have ample room to hold about 7,000 cattle. The cars in which this beef is transported are built on a similar principle and will each contain from 25 to 34 cattle. The meat is usually kept 43 hours before shipment, by which time all animal heat is surely expelled from the meat. It is from 3 to 4 days on the way to Boston, New York, Philadelphia or Baltimore, and on the way the ice is re-supplied four times, thus beef sent from this place is at least seven days old when it reaches the New York market. In the winter time the same temperature is maintained, but, of course, the ice needs only to be replenished twice.

Beef which has been thus refrigerated will keep out of the refrigerators perfectly sweet and wholesome two days even in the hottest weather. It is unnecessary to state that ordinary beef, not so well cleansed and not having the animal heat so thoroughly removed will not keep nearly so long.

This concern uses about thirty-three car loads of fresh ice per day. As each car averages fourteen tons, this makes about five hundred tons per day.

Ice is very cheap here, so much so that it does not even pay to manufacture artificial ice, much less to use any chemical or artificial means of cooling. One notable fact

connected with this process of slaughtering cattle is that the hearts of animals so killed are always empty of blood, whereas, those killed by other processes are generally full. Beef thus prepared is sent by rail to the coast, shipped in similar refrigerators on steamers to Liverpool and London, where it is taken out of the coolers, carted and sent by ordinary rail-car to Smithfield and other markets in England, and has always been in good condition and superior to English beef. In one instance meat was thus kept forty-three days on a disabled steamer and yet was in fair condition on arrival in England.

There has been considerable prejudice created against this so-called Chicago dressed beef by ignorant and malignant misrepresentation sometimes willfully confounding inferior canned beef which, because it is also packed in Chicago, has been called "Chicago Beef;" and again while the writer has frequently seen butchers selling Chicago dressed beef as home dressed beef, while they were vigorously declaiming against this Chicago stuff and pointing out inferior home beef as being Chicago meat. It has got to be quite customary now with careless reporters whenever justly or unjustly meat has been spoken of as the cause of sickness, glibly to describe it as Chicago beef, and thus creating an unfounded prejudice against what is really a wholesome, palatable and cheap article of diet. Many districts of country which have heretofore suffered for the want of tender, toothsome beef, are now well supplied from this source. About four thousand head of cattle are daily slaughtered in these establishments.

Some of the prejudice against this beef has been created by the ignorance of the so-called leaders of workingmen who led them to believe that by using Chicago meat they were injuring their fellow-workmen along the various railroads between Chicago and the Atlantic board, as well as those in the Eastern slaughter-houses. The fallacy of this belief is too evident to require argument.

DELUSIONAL MONOMANIA.*

REPORTED BY M. H. BOCHROCH, M. D., CLINICAL ASSISTANT.

G. B., æt. 47, white, married, a cabinet-maker, and Prussian by birth, came to the Polyclinic alone, and complained that he had been poisoned by his wife. He said that he suspected his wife of putting poisons in his food. After taking milk, the day before coming to the service, while at work, he experienced a pulsation of vessels over the whole body. He said that he had been in this country for a year, and was perfectly well until the arrival of his wife, when he began to have weak spells, and also noticed a discoloration of the urine. He was the father of ten children, and thought their mother was trying to mislead them. He heard noises in the rooms which his daughters occupied at night; and was in a peculiar condition; for, though awake, he could not get up and find out the cause of the noises; there seemed to be some peculiar power over him, which kept him down. His wife had a goitre, which she painted with iodine, and he believed that she also mixed this with butter in preparing his meats. She got him so confused in Germany that he was unable to take care of his stock of goods, and in this way cheated him out of his fortune. His wife, he said, was from the chief wine-raising district of Europe, and was an expert in the mixing of wines, having learned the business from her father. He believed that his brother-in-law was affected as he was himself, through her doings.

He had noises in his ears, like the escape of steam, but never had heard any voices. He was sure that his wife was not true to him, that she went with other men. He had tried, in Germany, to obtain a divorce on the strength of her attempts to poison him, but the judge, much to his disgust, ignored the case and advised him to come to this country. His wife followed him in about a year.

When he was under the influence of her spells, he thought his sexual powers were injured. He was confident that she used some of her menstrual discharge to produce this effect.

The wife of the patient was sent for, and said he had been out of his head for fifteen or eighteen years. He sometimes got violent spells and struck her. He suspected everybody coming to the house. He had bought a book on poisons, and had tried to study the diseases which they produced.

* Read before the Philadelphia County Medical Society, September 17th, 1884.

Just now he thought that his peculiar symptoms were due to opium poisoning. He had no tremor; apparently no loss of memory. He had never been a hard drinker; he drank beer and wine at times, but not to excess. He was an intelligent man outside of his delusions. Nothing of a satisfactory character could be learned with regard to his family history.

OBSERVATIONS IN ONE HUNDRED AND THIRTY-SEVEN ABDOMINAL SECTIONS.

Abstract of a paper read at the Annual Meeting of the American Academy of Medicine at Baltimore, October 28, 1884.

BY R. S. SUTTON, M.D., L.L.D., PITTSBURG.

The cases upon which these observations are founded were operated on by various operators in Scotland, England and Germany, Austria, France and the United States. Twenty-nine of them have been operated on by myself at Pittsburg. The cases comprise McDowell's, Batty's and Tait's and Heger's operations on the ovaries and tubes; cholecystotomy; supra-vaginal hysterectomy; resection of the pylorus; resection of portions of the bladder wall and of the small intestine.

In the United States the rule has been to perform ovariotomy after the general health has been broken, and to do the operation at the home of the patient. In England, Scotland and Germany early ovariotomy is much more frequent, and the patients are usually lodged and operated on in hospitals especially intended for such cases. In these countries the best statistics prevail.

Every ovarian tumor is at some time free from adhesions, and we may say that all young ovarian tumors are easy of removal; and the operation, when thus simple, is not dangerous. If a patient neglects herself, or if a bad medical adviser treats her with the trocar and persuades her to wait until death stares her in the face before consenting to an operation, the result is adhesions and neurasthenia, and, probably, brown atrophy of the heart, or atrophy or engorgement of the kidneys, and such cases will ever yield a large mortality, let the operator be who he may. I have been gradually approaching three conclusions in my own mind.

First. Nearly all cases of ovarian cystomata recover if operated on early under proper precautions.

Second. A very large number of cases of ovarian cystomata die if operated on after frequent tappings and long delay, in their own homes, under ordinary precautions.

Third. That simple cases and a well regulated special institution for the work will always be the mainspring of success in McDowell's operation.

The future improvement of the statistics of our own land will depend upon two things mainly: first, earlier operations; second, on greater precautions of safety in regard to the operator and the place of operation.

Age is not a barrier to ovariotomy. As a rule, young subjects do best, but often elderly subjects bear the gravest intra-abdominal operations very well.

Climatic influences have, probably, little to do with results in abdominal surgery. Pure air, hot or cold, in bountiful supply is of the utmost importance in the apartments of those recovering from surgical operations. The antiseptic wave has swept by; it has left us all the clearer; it has done immense good. If we will continue to "wash and be clean" even to the minutest details, carbolic acid or other chemical spray may be dispensed with. A greater precautionary measure than chemicals, lies in the daily habits of the operator, his assistant, and his nurses. Fewer spectators will insure less risk of infection. Crowds about an abdominal section are more dangerous than climatic influences.

The prevention of the loss of blood is of great importance, and stands next to drying out completely the abdominal cavity after the operation. The best appliances for arresting hæmorrhage are Kœberle's hæmostatic forceps. The intra-peritoneal method of treating the pedicle is the best, and the introduction of the clamp by a great English surgeon was a misfortune. In supra-vaginal hysterectomy the question of disposition of the pedicle, is the most important *sub judice:* the Germans favor the intra-peritioneal method; the English and Scotch the extra-peritoneal method. The latter, thus far, show the best results.

In the Hegar-Tait operation, the pedicle

of the ovary and tubes is secured by ligature, and is dropped into the pelvic cavity.

In operating, simplicity of manner is the easiest and most commodious; the standing position on the patient's right is the best. When a cyst is multilocular, a trocar is safest, for some fluids are irritating and least likely to escape into the abdominal cavity, when a trocar is used.

As the cysts are emptied, the abdomen should be filled with warm sponges, that the intestines may be protected from chill or soil. Adhesions are best treated by ligation and division with Pauquelin's cautery.

The best super-dressing after hysterectomy with the stump outside, is iodoform gauze. Dr. Bantock has had fine success with thymol gauze and Dr. Keith with an eight per cent. solution of carbolic acid, in glycerine, applied on gauze well saturated. Drainage in intra-abdominal operations should be resorted to only in cases when it is not certain that the bleeding is all arrested, where many adhesions were divided without the cautery, and when the peritoneum is so irritated that it is almost certain to throw off much serum. Drainage tubes during the first twenty-four hours create but little, if any, irritation; but after this time expires, they are constant sources of danger if left. In all these operations, as well as enterotomy, the best suture is silk well scalded or boiled, either in plain water, or a one in twenty solution of carbolic acid. In uniting the ends of intestine, or the walls of the stomach, the sutures should not include the mucous membrane, and the first row should be fortified with a second, including only the peritoneum, a combination adopted by Czerny and Lembert. Wet instruments are more comfortable, and if taken directly from the bath and replaced again until needed, they insure greater cleanliness. Blood does not dry on them, and they are more easily cleaned after the operation is completed. For closing abdominal wounds straight, smooth, well pointed needles are the best, and for uniting intestinal surfaces, a curved needle without a cutting-edge is excellent. White silk is the best suture to leave inside of the abdominal cavity; it is second to the silkworm gut, for uniting the abdominal wound. The latter suture should be used wet, and is superior to silver wire; it may be left in the tissues indefinitely. The manner of operating in intra-abdominal operations differs widely, but simplicity and care in the details of preparation and finishing, are two very important points. I may be pardoned for intruding upon you my own habits in regard to abdominal operations.

a. The room contains no furniture beyond a bed, a table and chair. The floor is bare. The walls and floor are scrupulously cleaned with soap and water, as well as is also the scanty furniture; as soon as dry, the floor is wet with mercuric chloride 1-2000.

b. The instruments are all scalded, then cleaned with soap and water, then rescalded and dried, then one by one are put into an alcoholic bath and dried again. Each forceps, tenaculum and needle is passed through the flame of a spirit lamp. They are now placed in order in clean brass pans and left carefully covered with clean towels, until the hour of operation arrives. The sponges are taken directly from a five per cent. solution of carbolic acid, in which they have remained for at least seven days.

c. The patient receives a full dose of compound liquorice powder, often with a drachm of sulphate of magnesia, thirty hours before the time of operation. On the morning of the operation day (hour 2 P. M.), she receives a complete washing in the bath tub, and her vagina is also exposed to a copious douche of hot water. From the bath she goes into clean clothes, and into a clean bed adjoining the operating room. She has a full breakfast, and does not know that her operation is coming until she is refused dinner at 1 P. M., when she can only suspect it.

d. The nurse or nurses (never more than two) who assist, take a bath and dress in fresh clothes.

e. The operator and assistant do the same, and on the eve of beginning, all hands are washed in turpentine and then with soap and water. One nurse gives the anæsthetic, one waits upon me and my assistant stands opposite me.

f. Spectators are limited to the patient's physician and two others. They touch nothing, and I usually insist that all coats be left in the hall.

g. The operation: The patient is anæsthetized by the nurse, and carried on a board to the table. She is firmly secured, a can of hot water is placed at her feet. Her abdomen, chest and extremities are

covered with a rubber sheet, exposing only the region required for the site of operation. Over the rubber sheet are placed towels wrung out of boiling water. The surface exposed is now rubbed off with a wet, carbolized towel. As the operation proceeds clean towels are thrown over the soiled ones. The instruments are lying in a bath of hot water at the right of the operator. The sponges are steaming in a double bucket ready for use. In summer no fire is used; in winter a temperature of at least 80° surround us all.

The operation is done slowly; the anæsthetic is given sparingly after the start is made. The sole responsibility for the operation is concentrated in the operator. Every drop of blood is considered valuable and is saved if possible. The cavity of the abdomen is left dry, and the wound, after being closed very accurately, is covered with antiseptic dressing of iodoform and carbolized cotton.

With the small force enumerated, all intra-abdominal operations are done. As soon as the dressing is secured and the patient released, she is removed to a bed already well warmed by means of hot-water cans. A third of a grain of morphia is given hypodermically and she is left to a nurse. If a drainage tube has been left in the lower angle of the wound, it consists of glass and reaches to the bottom of the pelvis. Its mouth is secured by a sponge held in place by a thin rubber sheet, which is perforated by the tube. The sheet is folded around the sponge. The tube is frequently examined, and a little iodoform is dropped into it after it is emptied by the suction of a syringe, to which is attached by means of a rubber joint, a celluloid catheter with the curve cut off. I never leave a drainage tube without feeling, that while it may do good, it may do harm, and I always feel better about the case when I get the tube out.

Abdominal operations are growing more frequent every day. Even in my little field of work, within a period of twenty months, I have opened the abdomen twenty-two times. Sometimes I am asked about a diagnosis. For a year or more I never worry about a diagnosis. Professor Von Billroth told me, three years ago, that he didn't care much about it any more, and Mr. Lawson Tait told me that he couldn't always tell what sort of wood lay under the table-cloth. I followed my teachers, and I now look out for pregnancy, cardiac and renal diseases only, and leave the character of the growth to be determined on the operating-table. Of course there are plain cases, but if the cases are doubtful, I abide the time of operation to determine the character of the case.

In regard to selection of cases for abdominal section a few words may be well said. Some cases are absolutely plain. A man or woman with a bullet wound through the abdominal cavity could scarcely be considered as having a chance for life with a doctor who simply sat by, gave opium, and waited the time to write the death certificate.

It is not long since a woman, in the city of Pittsburg, shot through the abdomen lived a week lulled by opium to death; the *post mortem* revealed an intestine severed by the bullet. Can we afford to sit by and give anodynes in such a case, simply because the ignorant relatives oppose a surgical operation? It is our duty to retire and refuse the responsibility? There are cases offering for ovariotomy which I am sure should be refused operation. Given such a case, tapped a dozen times, the health all shattered, the last drop of life ready to depart with the last ten dollar bill left in her pocket by the persistent tapper. Is a man with a decent record, called upon by humanity, or anything else, to operate on such a case? When a doctor knows that repeated tapping is destroying a patient's chances of ultimate cure, and goes on doing it, he is doing an injury to the patient, to himself and to the profession. Cases thus ruined have no just claims in themselves or through their doctors, to surgical operation at the hands of any man who values his statistics. The death of every such case after operation, puts another life in jeopardy because it makes her stand off and avoid early operation; I have had my share of these deplorable cases, and I am every day getting nearer to that state of determination, when I will refuse to operate upon them.

In hysterectomy for fibroids we find a field very different from ovariotomy. Every fibroid tumor will not of necessity destroy the woman. If she is seen early, oöphorectomy or even judicious treatment may be sufficient. But when the tumor is large, or has undergone cystic de-

generation, hysterectomy may be demanded. The only cases I am really afraid of under these circumstances are those in which the pelvis is full of the tumor. When it dips down onto the rectum between the layers of the broad ligament and fills the pelvis almost entirely, the upper end of the tumor reaching above the umbilicus, the case is desperate.

If a fibroid tumor is causing no distress, is not affecting the health of the patient, is not growing, it is wisdom to let it alone. If, on the contrary, it is bleeding the patient, growing and distressing her, or interfering with her earning her daily bread, the case is one for surgical operation. Should, however, her menopause be near, the hemorrhages should be treated and an effort made to hold over surgical operation, until the effort of the menopause is given a chance to arrest the progress of the growth. Many cases are not plain and no amount of examination is likely to determine them before exploratory incision is made. This procedure is safe under proper precautions and is legitimate.

The most important point now under judication, in abdominal work, is the place in which the operation should be done. Thus far it will be found that the house of the patient has given the worst statistics,and Mr. Lawson Tait says, "A woman who has ovariotomy done at home is a fool for her pains."

The method of operating may be followed anywhere possibly, but the quarantine of a special hospital is very important, and the surgeon has full control of his patient. In England and in Europe hospital facilities have given the best results; we may instance the statistics of Wells, Bantock, Thornton, Tait and Keith. In our own country we will come to it, and it is fair to believe that our statistics will be improved by it. My own hospital has only been open a year, with a great variety of cases, many of them really of desperate character. I get only the worst cases so far, and it will take another year or two to decide what the institution will do for my own statistics. What is wanted now in this country most of all to improve this branch of surgery is a clinic. Such a clinic for abdominal surgery should be protected against infected spectators, but opened to a limited number daily, who will observe the restrictions which should be imposed. It should be completely equipped, under the exclusive command of one surgeon. There are very few institutions in the United States which could afford this feature of education. But if the Johns Hopkins University, of this city, would add this feature, it would greatly benefit the profession and do a great deal for suffering humanity also.

MURIATE OF COCAINE IN LABOR.

BY J. R. UHLER, M. D., OF BALTIMORE, MD.

For some years I have been in the habit of using dilute solutions and o ntments of carbolic acid, both as disinfectants during examinations and to mitigate the pains of labor, but lately have thought that local anæsthesia can be more thoroughly induced by the employment of muriate of cocaine, either in solution alone or associated with dilute carbolic acid. A few days ago I had an opportunity of testing it upon a multipara, during the birth of her seventh child; and, though the quantity of two per cent. solution employed was small, and the difficulties of keeping it *in situ*, owing to discharges, great, yet the results were satisfactory enough to encourage us to give it further clinical trial.

The case was not seen until the neck of the uterus was well dilated, nor was any of the drug purposely applied to the os, but at each examination after the discharge of the amniotic fluid, a few drops of the watery solution were smeared by the index finger around the labia and vagina, producing anæsthesia in spots, but more on the anterior than the posterior portions, probably because the drug in this situation, with the patient on her back, was not so readily washed away.

The uterine pains did not seem to be interferred with, but owing to anæsthesia of the vaginal walls, the voluntary straining efforts of the patient were not so prolonged as they had been in the other labor in which I had attended her, nor was the last pain severe enough to make her cry. Had the case been seen earlier, and the drug been used of greater strength and more freely, or been applied in such a manner as to prevent its being washed away by the discharges, a still better result would no doubt have been produced. As it was the case ended rapidly and very satisfactorily to both mother and child, and the former did not suffer from the after soreness, which is such a common accompaniment of ordinary labor.

234 W. Fayette Street.

Society Reports.

NINTH ANNUAL MEETING OF THE AMERICAN ACADEMY OF MEDICINE.

HELD IN HOPKINS HALL, BALTIMORE, OCT. 28TH AND 29TH.

(*Specially reported for Maryland Medical Journal.*)

FIRST DAY.

The meeting was called to order at 3 P. M. by the President, Dr. Benjamin Lee, of Philadelphia. After the reading of the minutes of the last annual meeting by the Secretary, *Dr. Richard J. Dunglison*, of Philadelphia, the report of the Council was heard on the names of forty-one candidates for Fellowship in the Academy. Upon motion, the candidates were elected by the cast of the Secretary's ballot.

The Committee on Nominations was then appointed, after which the reading of the papers for the day was commenced.

The first paper, by *Dr. Peter D. Keyser*, of Philadelphia, was entitled "The Relation of the Medical Colleges to Preliminary Education." In the consideration of the subject, Dr. Keyser said, that judging from statements made by the colleges, there was some improvement shown in regard to the requirement of matriculation examinations and the adoption of graded courses of three years; but, whether the colleges would in all cases abide by their statements, the future would alone reveal. In many States the doors of the colleges are so loosely hung that the usual fee of five dollars alone is sufficient to open them to all who seek their honors. In Maryland the standard is low. In Pennsylvania the State Society does not allow its members to take students into their offices without a previous examination.

Illinois has raised the standard by the passage of a law on the subject, and it is the only State which can boast of a high standard. Dr. Keyser then submitted statistics as follows: Number of medical schools in the United States, ninety-one; number requiring matriculation examinations, sixty-one. Formerly the latter class numbered only thirty. Number requiring for graduation a three-years' course, sixteen; number recommending, but not requiring such a course, forty-three. The colleges coming under the foregoing heads were then named. In the list of colleges requiring of the student a preliminary education, fifteen have put their standard so low as to render it virtually no requirement at all, and but few of the remainder carry out their standard, the simple guarantee of the preceptor being often taken as sufficient proof of the education of the student.

The result of a high standard on the number of students is marked; the difference in the attendance of the colleges enforcing a high standard, and those whose standard is low, amounts to fifteen hundred in favor of the latter class. The consequence is an over-crowding of the profession with incompetent men.

Dr. Edward Jackson, of Philadelphia, then read a paper on "The Examination of Applicants for License to Practice, a Means of Raising the Standard of Medical Education." After referring to the deplorable laxity of license laws regarding the practice of medicine, the author spoke of the plan providing for the appointment and maintenance of State examining boards, as being the best yet proposed. In his opinion a law requiring examinations by State examiners, uncontrolled by the schools, by whom a license to practice would be given if the applicant prove efficient, was the only sure means of raising the standard of medical education; because, without it, there is no direct and controlling competition regarding the attainments of the graduates. There is no other means of judging of the relative value of the teachings of the schools, at present the number of students being the only data at command for grading the schools. The student looks upon the degree simply as a money-getting license, not as an honorable certificate of his attainments. A State examining board should not bestow medical honors or endorse the diplomas of medical schools; but should simply examine with reference to giving a license to practice, and thus protect the public from gross ignorance couched behind a professional degree. A single State board was the best plan, having, if need be, homœopathists, electics, etc., upon the board, to examine with regard to the therapeutics of their respective schools, after the general examination had been gone through with. The term of office of

the State examiner should be a long one and his salary should be large.

DISCUSSION.

Dr. Marcy, of Boston, spoke of the examination for license at Berlin, which was even dreaded by students who had passed the University examination following a four years' course. An apothecary cannot put up prescriptions from any but licensed physicians.

Dr. Roberts, of Philadelphia, endorsed Dr. Jackson's views, and thought them the best means yet proposed for elevating the standard of medical education. He had great hopes of the passage of a law of this kind for Pennsylvania within a few months.

Dr. Sell of New York, spoke of the Austrian examination for license. After receiving his degree there, he was required to give bond not to practice without first passing the requisite examination.

Dr. Jas. Cheston Morris, of Philadelphia, spoke of such examinations in London, where the teachers have no control whatever of the examining board. Continuing, he referred to the existing laws requiring examination in New Jersey and Maryland, and asked Dr. Steuart whether, in the latter State, the laws were still in operation.

Dr. James A. Steuart, of Baltimore, said in reply that the laws, although on the Statute Book, had long ago fallen into disuse. A bill drafted from the laws of Illinois and West Virginia had been presented by him to the Maryland Legislature, but had been defeated by the medical men having seats in that body. He does not despair of ultimate success.

Dr. Keyser, of Philadelphia, said that in 1870 he drew up a bill after the Prussian method, excluding the schools from all control, and it was smoothered by the schools when it came up before the Pennsylvania Legislature. Having himself passed the Prussian examination, he knew it was entirely separate from, and independent of that of the schools.

Dr. Sibbet, of Easton, Pa., said that a bill to succeed should not mention anything in favor of, or against homœopathists, etc., in regard to the appointment of examiners; but that such appointments should be based simply upon high qualifications.

Dr. Steuart, of Philadelphia, said that the regulations for preliminary examinations must be national, so as to meet the sectional competition of the schools of different States. He would advise a State preliminary examination, as well as, one for licensing to practice.

Dr. Jackson, in closing the discussion, said, that he had no hopes of an early passage of such a bill in Pennsylvania, but that the importance of ultimate success was worth all the labor that could be expended upon it.

"THE RÔLE OF BACTERIA IN INFECTIOUS DISEASES" was the title of the next paper, read by *Dr. Henry O. Marcy*, of Boston, Mass. This was an able defense of the germ theory of disease; with a review of the work of investigators, and its importance with reference to the etiology and treatment of infectious diseases.

Dr. Albert H. Gihon followed with a very humorous paper on "THE TRADE ASPECT OF MEDICINE." The speaker hit straight and hard at the "tradesman doctor:" the man who will let the poor suffer because they are unable to pay him his fee; who complains against dispensaries and hospitals, because by relieving the bodily sufferings of the poor, they may be the means of depriving him of a few dollars; who does not approve of sanitary measures for fear that the expected sickness (which lines his pocket) will be prevented. The so-called "doctors" of this stamp were held up to just ridicule.

Dr. John B. Roberts, of Philadelphia, offered a resolution, providing for the appointment of a committee of two for each State, having Fellows of the Academy residing therein, to urge the necessity of a board of State examiners in medicine, whose certificate shall be the only document accepted as a license to practice.

The session then adjourned to reassemble at 8 P. M.

EVENING SESSION.

THE PRESIDENT'S ADDRESS.

The President, *Dr. Benjamin Lee*, of Philadelphia, addressed the Academy on "DIFFERENTIATION THE TEST OF CIVILIZATION: THE SPECIALIST AND HIS EDUCATION." He said the occasion was an appropriate one for the discussion of the subject, as

specialism had been first recognized in Baltimore in 1805, by the Medical and Chirurgical Faculty of Maryland, whose board of examiners licensed oculists to practice as specialists; and he could not pass without speaking of the valuable work of this Faculty in authorizing one of their number to prepare their "Annals," and to commend the meritorious and painstaking manner in which the author carried out the wishes of the Faculty, giving to us as the result a contribution to medical history of inestimable value. Specialism, he said, was the natural outcome, and, therefore, a test of civilization. We see it in the mechanic arts, the law of both this country and of England, and in the ministry of some countries of Europe.

The speaker then considered the arguments of the opponents of specialism; thoroughly analyzing them. He did not propose defending either side of the question. "But," said he, "in my own mind two points are fixed. They are: first, that the specialist is with us; secondly, that he has come to stay." For a specialist even a higher standard of preliminary education is necessary than for the general practitioner. The specialist's knowledge must be based upon a broad and liberal education; he must be surgeon as well as physician; his resources must be large to meet large requirements; he must be ever toiling, ever advancing; his speciality is a thirsty plant, requiring him continually to send out roots into the earth of knowledge to draw nourishment therefrom, else it wither and die. The speaker concluded his remarks with tributes to the memory of the Fellows and Honorary Members, deceased during the year just past. Dr. Frederick D. Lente, a former President, "a man full of good works;" Dr. J. Marion Sims, "honored at home and abroad;" Dr. Samuel D. Gross, "great by nature as by name. A king among men;" Surgeon-General Crane, "an honored and honorable life;" Dr. Elisha Harris, "Hygiene his goddess."

The session then adjourned to attend a banquet at the Athenæum Club.

SECOND DAY.

The session was opened at 10.30 A. M. by the announcement of the officers elected for the ensuing year.

President:—Albert H. Gihon, U. S. Navy.

Vice-Presidents:—R. Stansbury Sutton, M.D., L.L.D., of Pittsburg; Dr. James A. Steuart, A.M., M.D., of Baltimore; Dr. William Elmer, A.M., M.D., of New Jersey; Dr. J. Cheston Morris, A.M., M.D., of Philadelphia.

Secretary and Treasurer:—Richard J. Dunglison, A.M., M.D., of Philadelphia.

Assistant Secretary—Charles McIntire, Jr., A.M., M.D., of Easton, Pa.

Drs. Geo. M. Sternberg, U. S. Army, and Oliver Wendell Holmes were elected honorary members of the Academy.

The following resolutions were then adopted:

Resolved, That the American Academy of Medicine recognizes in the recent munificent gift of W. H. Vanderbilt to the College of Physicians and Surgeons of New York, a most important and valuable service to the science of medicine in America.

That in this spirit the Academy tenders to Mr. Vanderbilt its obligations with the assurance that in no better way could the higher education of our profession and the benefit of humanity be promoted.

Dr. A. D. Rockwell, of New York, read a paper on "The Induction Coil; Its Varieties and the Different Indications for Their Use."

Dr. Chas. C. Bombaugh, of Baltimore, followed with an interesting paper on "The Place of the Physician in Literature."

Dr. R. S. Sutton, of Pittsburg, Pa., then read a paper entitled "The Teachings Derived From Observation in 137 Abdominal Sections." (see page 17).

DISCUSSION.

Dr. J. Taber Johnson, of Washington, D. C., agreed with Dr. Sutton as to the importance of early operations and of perfect toilet of everything pertaining thereto; but he differed with him upon the question of operating with the patient *in extremis*. He thought the patient should be given her only chance of life, even at the risk of the operator's statistics.

Dr. Marcy said that Dr. S. had shown them that the antiseptic wave had not gone by, but *over* him, leaving good results behind it. Aseptic surgery is now what we want. He spoke of the rupture of an ovarian cyst, with death resulting from sep-

ticæmia. Micrococci were found in large numbers in the cystic fluid, not only of the ruptured cyst, but also in those remaining intact. Life could have undoubtedly been saved had abdominal section been performed.

Dr. Sell, of New York, said that he could express the result of his experience of over three years in Europe, in two phrases:—"Absolute care, with absolute cleanliness." He believed in operating in desperate cases, as he had seen some survive when there was absolutely no hope of their recovery entertained. He thought that the after-treatment is most important and should have the personal attention of the operator.

Dr. Sutton said, in closing the discussion, that he would not operate unless he could give his personal attention to the after-treatment. He had often operated in desperate cases, but he thought he knew now where to stop. He thought, also, that if operators will not operate on old cases, which have, by tapping, been kept alive, but rendered unfit for operation, the attending physicians would refuse to tap and insist on an early operation.

President Gilman, of Johns Hopkins University was then introduced; and, after a few remarks with reference to the University, he invited the Academy to visit its various departments.

After re-assembling, the following papers were read by title and referred to the Council:

"Some Comparative Results of Treatment of Chronic Articular Osteitis of the Hip," by Dr. Virgil P. Gibney, of New York.

"The Aim in Treatment of Angular Curvature of the Spine," by Dr. T. M. Ludlow Chrystie, of New York.

"Physiology in Its More Public Relations" (Public health, physical culture, family institution, true civilization), by Dr. Nathan Allen, of Lowell, Mass.

"Specialties and Their Relation to the Medical Profession" was the title of a paper read by *L. Duncan Bulkley*, of New York. The author thought that a specialty should have a natural outgrowth from a general practice; and he advised young men to seek hospital experience before taking up a specialty. It was his opinion that the future of medical specialties would be limited to difficult cases, commanding larger fees; and, that like all else, it would be regulated by the law of supply and demand. Specialists were every day enlightening the profession with regard to the diseases coming under their special care; and the solution of the question of specialism was necessarily this:—the coming medical man will be so well informed that all except bad cases will be treated successfully by the general practitioner.

The last paper of the session was a "Report on Laws Regulating the Practice of Medicine in the United States and Canada," by Dr. Richard J. Dunglison, of Philadelphia. After which the Academy adjourned to accept the offer of Dr. J. S. Billings to escort them through the buildings of the Johns Hopkins Hospital.

CLINICAL SOCIETY OF MARYLAND

STATED MEETING HELD OCTOBER 3RD, 1884.

(*Specially reported for Md. Med. Journ.*).

The one hundred and forty-fifth meeting of the Clinical Society was called to order by the President, Dr. J. E. Michael, at the usual hour. After the transaction of some routine business, nominations were made and officers elected for the ensuing year.

Dr. J. N. Mackenzie read a paper upon the subject of Coryza Vaso-motoria (Hay Asthma) in the negro. The doctor introduced the subject by referring to the absence of the hay asthma in the negro; and then related the following case as being, so far as he was aware, the first recorded instance of the affection in a race in which its occurrence has been denied.

J. M., aged 35, unmarried, a tall well-proportioned colored man came under his care September 6th, 1884. He had always been healthy except a tendency to catch cold upon exposures to the most trivial causes. Emanations from hay have always excited a coryza of great severity. For four years past he has had a sensation of stuffiness of nostrils, with dyspnœa on exertion, accompanied by a slight post-nasal discharge. The trouble has been worse of late. At times the attack is ushered in by a tickling or itching in upper and back part of throat, sometimes by violent sternutation, a discharge taking place with obstruction of nostrils. Eyes became red. About an hour after the attack asthmatic symptoms set in, which are worse at night. His trouble lasts from second week in August

to late in September, and leaves him in a state of nervous prostration. His present attack was so severe as to compel him to quit business. He rarely suffers from his attacks between April and second week in August, he never escapes the latter period. Sudden changes, coal dust, use of tobacco, greasy smell of kitchen, dust from articles, as carpets, etc., are all exciting causes of his attacks.

Flowers, light and diet, however, will not excite the trouble. No symptoms pointing to a disorder of the nervous system have shown themselves until the asthmatic trouble set in. The only relief he has obtained has been by inhaling proprietary pastiles. Examination showed nasal and lower pharynx conjested, post-extremity of lower turbinated bones engorged, swollen, bright red and covered with a translucent film of mucous. Erectile tissue of right side of posterior part of septum hypertrophied. Only along the inner side of left inferior turbinate body, about 1¼ inches within the nostrils, could reflex be produced; and here the most exquisite paroxysm of asthma followed simple contact of probes. A superficial incision was made in the sensation spots with the galvano-cautery. On the night after operation the patient had a slight paroxysm which passed off in an hour. The next five days he enjoyed perfect immunity from the disease; he then took cold and the trouble returned. The Dr. then gave his views of the etiology of the affection. Looking upon this disease as a coryza generally dependent upon abnormal excitability of the vaso-motor centres, it does not seem justifiable to confine the operation of its cause to any particular country as to explain its phenomena on the hypothesis of national or race peculiarities; it is found in all ages and conditions of life and it is possible that it may be hereditary from father to son. In some cases the exciting cause is found in a variety of different agents, in others only one. Meteorological causes should be given a prominent place. In the black race, the exquisite delicacy of the sense of smell, the prominent development of the turbinate bones, would seem to invite the paroxysm in those surrounded by the conditions which provoke it. The Dr. concluded as follows: I have several times met with reflected phenomena in the negro, referable to diseases of the nose and belonging to the same category of reflex affections, and it is possible that a fair proportion of cases of the convulsive asthma which occurs in that race have been of similar origin.

While the above case is the only instance of the occurrence of the disease in the negro that has come under my notice, it is quite possible that if looked for it may be more frequently found.

In reply to a question the Dr. said his patient was black and not a mulatto.

Dr. R. M. Hall exhibited a monstrosity known as cephalo-thoracopagus. There were well developed upper and lower extremities, perfect genitalia; the trunk was fused above the insertion of the cord.

Correspondence.

Editor Md. Medical Journal:

BALTIMORE, Nov. 3d, 1884.

SIR:—In your editorial comments on the recent meeting of the American Academy of Medicine, in your issue of Nov. 1st, you remark: "Such members of the profession as are eligible to Fellowship under its rules should cast their influence with the organization." I submit, with the utmost respect for the gentlemen composing the Academy as well as for yourself, that this advice is neither consistent with your own views, as expressed elsewhere in the same article, nor conducive to the best interests of the profession. You say in the same editorial: "It is well known that some of the most brilliant men in the medical profession have never enjoyed the benefits of any save the plainest educational advantages prior to entering upon the study of medicine," and, "The standard erected by the Academy as a test of fitness for membership does not seem to be altogether just. The A.M. and A.B. degrees no more indicate the status of the scholar than the M.D. degree does that of the physician." The truth of these statements is patent. They mean that a classical education is not essential to the attainment of the highest professional eminence, and that the possession of the degree of A.M. or A.B. even, as a test of this unessential distinction, is perfectly worthless. The artificial barrier with which the Academy surrounds itself, admits any insignificant A.B., whose influence in the profession may be good, bad or indifferent, while it excludes many of

the most capable, prominent and influential physicians in the country; men who, for the most part, are earnest advocates of the very principles which it is the mission of the Academy to disseminate, viz:—the elevation of the standard of medical education. Many of the men whose names adorn the pages of medical history could not have enjoyed the distinction of membership of the American Academy of Medicine. Nay, many, of former times as well as of the present, although thoroughly educated and highly cultivated, would be debarred because, forsooth, they could not write A.B. or A.M. after their names. But we need not seek examples in other times or places. A glance at our medical teachers, as well as at other gentlemen who give character and tone to the profession in Baltimore, will show the inefficiency of the test. If the much needed elevation of our standard is to depend on the A.M.'s and A.B.'s among us the prospect is gloomy indeed. Now I would not for a moment call in question the sincerity of the Academy. There can be no doubt but that the gentlemen composing that body are earnest and zealous in preaching their mission. It is equally obvious that the ends they strive for are equally desirable for the profession and the public. The better part of the profession everywhere is working toward the same goal. But can the Academy hope to succeed by its present methods? Can it expect to exercise much influence on a profession, against a great majority of whose most prominent members it shuts its gates? Is not its nine years of almost fruitless existence an answer to the question? I am inclined to the belief that the organization errs fundamentally in its requirements for membership, and that its exclusiveness, based as it is upon a non-essential distinction, will always be a bar to its usefulness, and tend more to the cultivation of a medical pharisaism on the part of those within, than to the improvement of those without its pale.

I am very respectfully,

ARTIUM MAGISTER.

Editorial.

FOREIGN BODIES IN THE ABDOMEN AFTER LAPAROTOMY.—It not infrequently happens that foreign bodies are left in the abdomen after laparotomy through the inattention or mishap of the operator. The presence of a sponge, or forceps enclosed in the abdominal cavity would seriously jeopardize if not defeat the success of a laparotomy, however skilfully performed in other respects. Naturally enough surgeons are slow to report such accidents, and it is believed from the number of such cases recorded that this accident is not an uncommon occurrence. Dr. H. P. C. Wilson, of this city, in a paper read before the recent meeting of the *American Gynecological Society* on this subject, stated that after a laborious search he had been able to collect but twenty-one cases, of which only six had been published. Of these six published cases, the foreign bodies were sponges in four, and forceps in two. Four patients recovered, two died. Five of these cases occurred in Europe and one, the case of Dr. Wilson, in America. The five published European cases occurred in the practices of Lawson Tait, Sir Spencer Wells, Karl Braun and Gustave Braun. In the case of Lawson Tait, an excited bystander had torn one of the twelve sponges, habitually employed, into two pieces. The torn sponge was found in the abdominal cavity four days later.

In the first case reported by Sir Spencer Wells, the sponges were counted by a nurse, and sixteen were asserted to be present. The next morning two sutures were removed and the sixteenth sponge was found in the abdominal cavity. In the second case, reported by Sir Spencer Wells, the foreign body was a pair of forceps, which were found wrapped up in the omentum.

In Dr. Wilson's case, a sponge was enclosed in the abdomen, when a laparotomy was performed. Some weeks after the operation an abscess formed in the lower angle of the abdominal wound, and a quantity of fetid pus, with bits of sponge were discharged through the orifice. The patient made a final recovery.

Dr. Wilson's experience has prompted him to formulate the following rules for the prevention of such accidents:

1. Count and record all sponges and instruments.
2. Use as few instruments and sponges as possible.
3. Let the operator sponge himself.
4. Let the assistant's functions be confined to handing instruments and sponges.

5. Let the sponge be perfect in texture and strong; never allow the division of a sponge, and use as few small sponges as possible.

6. Let compression and torsion forceps be large.

7. Employ only two assistants in addition to the etherizer.

8. Let the operator himself verify the record before closing the abdominal incision.

In the discussion following Dr. Wilson's paper, Dr. T. G. Thomas, Dr. Reeves Jackson and Dr. Geo. J. Engelman related similar experiences in which foreign bodies had been left in the abdomen after laparotomy. Dr. Thomas had performed laparotomy between three hundred and four hundred times, and had had one case in which a sponge was found in the abdominal cavity after death. He thought the accident due to the friability of the sponge, as he made it a rule to count and record all sponges and instruments. Dr. Thomas has adopted the plan of using as few instruments as possible, and he now attaches to each of his sponges a tape six inches in length, usually of a bright color. These tapes hang outside of the abdominal wound. Dr. Thomas also removes all artery forceps from vessels as soon as possible, and secures the bleeding points by torsion or ligature. An excellent point was made by Dr. Mundé, who suggested: 1st. That friable sponges or such as have deteriorated by use or disinfectants should never be used. 2nd. Never cut sponges. 3rd. Always use sponge holders.

In view of the importance of this subject the suggestions offered by Dr. Wilson and the gentlemen named are worthy of careful consideration.

Valuable Suggestions to Medical Students.—In an able and scholarly address delivered before the students of St. Thomas' Hospital Medical School, at the opening of the present session, and published in the *London Medical Times*, Oct. 4, 1884, Sir James Risdon Bennett presented a number of valuable suggestions to students preparing to fulfil the duties of a professional life. The words of the speaker are full of practical wisdom, and will bear repetition before an audience of medical practitioners. We may be pardoned, therefore, for abstracting a few of the suggestions from so learned an authority.

The speaker, after a few introductory remarks of a general character, impressed upon his audience the importance of a general culture and preliminary education as a preparation for medical work. He advocated the study of mental philosophy in the curriculum of preparatory work. "For the direct purpose of our profession we need to give due regard to the reciprocal influences exerted between mind and body; to the moral powers with which we are endowed, and the modes in which they can be brought to bear on the welfare of our patients. The will, the imagination, emotions, affections, all exercise an influence on the aspect, course and final issue of disease. They require each in their turn due consideration from him who would rightly fulfil all that duty demands, or ensure his own success."

The speaker emphasized the importance of avoiding the two extremes of credulity and scepticism in investigating the complicated phenomena of life and all that concerns its maintenance, on the one hand; and, on the other, all that relates to the origin, nature and prevention of disease. The importance of a well-trained and regulated mind, in order to secure and make available for our great purpose in life, truth, and truth only, was referred to. Both the science and art of medicine are largely based on observation and collection of facts, and the observing powers of individuals differ; hence the speaker urged all to carefully cultivate their powers, and by habits of close and continual practice render them both quick and accurate. "Having ascertained, as carefully as may be, the certainty of our facts, the utmost care and honesty of purpose are required in tracing their mutual relations and drawing conclusions from them. All prejudice and preconceived notions must be excluded in determining whether any two facts stand in relation of cause and effect, and in deducing general principles from any number of facts." The habit of close reasoning and the exercise of sound judgment were considered essential to success in medicine, which presents greater difficulties than the physical sciences in applying the strict rules of philosophy to the investigation and determination of truth.

"We have," he says, "far greater difficulty in determining the uniformity of phenomena, arising from their greater variety and complexity, and also from an imperfect acquaintance with the influence of ex-

ternal agents on the living organism."

We must still submit to the taunt of the uncertainty of medicine, but, he affirms, that this uncertainty is daily decreasing. The speaker warned his audience against wasting time by studying so-called systems of philosophy which minister questions that are insolvable, and are fertile only in raising doubts and spinning ingenious fancies and improbable theories. "For the real purposes of life they are little better than verbal and vain janglings." The investigation of man's physical constitution, as the highest type of organic life, was the real problem to be solved by the student of medicine. The thorough study of health and disease must progress simultaneously; for anatomical or structural studies are most intimately connected with function, whether it be healthy, or physiological; or perverted, or pathological. Life is ever passing into death and the very actions by which life is maintained are ever working by sure and inevitable steps to the destruction of life. It is then the duty of the practitioner to modify, in some measure, these actions and to avert those causes that interfere with life. The knowledge of the exciting causes of disease is growing each year. The speaker urged the importance of study in this direction, as in the direct line of diminishing the danger to life and promoting health.

Referring to the great ardour with which histological investigations have been pursued during recent years, Sir James took occasion to warn his hearers against coming under the description of Goldsmith's "puny pedant, who finds one undiscovered property in a polyp, or describes a hitherto unheeded process in the skeleton of a mole, and whose mind, like his microscope, perceives nature in detail."

The discovery of fresh specifics was regarded as an important direction of scientific inquiry, for it is in remedies that we must find the means of exercising an influence over diseased action. The polypharmacy of the past has been a great evil. Simplicity in the use of remedies is considered conducive to more accurate knowledge of the real therapeutic value of medicines.

Hygienic rules, diet, and regimen, were considered under the head of therapeutics, and it is here that we have met with most success and have won our greatest triumphs.

An Important Legal Decision in West Va.—The Supreme Court of Appeals of West Virginia delivered its opinion on Nov. 1st. in a case brought up from a lower court: —that the law regulating the practice of medicine and surgery in that State "is constitutional and valid." The learned opinion delivered by Judge Green at once places the State Board of Health in West Virginia on high legal ground, and will enable the Board of that State to protect the people of West Virginia from quackery, which thrives so vigorously in other sections of our country. It is believed the opinion of the court will have a far-reaching effect in elevating the practice of medicine in other States. The profession of West Virginia is to be congratulated upon this result of an attempt to undo the excellent work that the State Board of Health has undertaken in that State.

Miscellany.

The Legal Enforcement of Study at Home.—A novel suit, involving health questions, has recently been decided in one of the English Appellate Courts. A teacher in one of the public schools prescribed certain lessons which were to be learned at home, and when these were not satisfactorily committed to memory a difficulty arose between the teacher and scholar, which is not fully detailed, but which gave rise to the charge of assault and battery against the teacher. The determination of the charge of assault does not appear, but the court where the case was originally tried, and the Appellate Court, both decided that "home lessons set by teachers cannot be enforced." This decision seems to hold that scholars cannot be held responsible for the learning of lessons at any other place than the school-room. It can hardly prevent, however, teachers from giving lessons of such length as to require study out of school hours, and if they are not learned the scholar's standing will necessarily be lowered. Such a result will, of course, modify largely the practical results of the decision. The attention of parents and teachers, here, as well as in England, cannot be too emphatically called to the question whether the requirements of home study, directly or indirectly made, are not in general too exacting for the proper

development of the health of children. *Med. Record.*

Washington Obstetrical and Gynecological Society.—At a regular meeting of the above named society, held October 17th, 1884, the following officers were elected for the ensuing year :

President: Samuel C. Busey, M. D.

Vice-Presidents: W. W. Johnston, M. D. and J. Taber Johnson, M. D.

Recording Secretary: C. H. A. Kleinschmidt, M. D.

Corresponding Secretary: Samuel S. Adams, M. D.

Treasurer: Geo. Byrd Harrison, M. D.

Committee on Business: C. E. Hagner, M. D.; Lachlan Tyler, M. D., and S. S. Adams, M. D.

Committee on Admissions: J. R. Bromwell, M. D.; H. H. Barker, M. D. and G. W. Acker, M. D.

Dermatitis Herpetiformis: Its Relation to so-called Impetigo Herpetiformis.—In an instructive article in the October number of *The American Journal of the Medical Sciences*, Dr. L. A Duhring maintains that the impetigo herpetiformis of Hebra and the pustular and other varieties of dermatitis herpetiformis are identical. Our knowledge of the disease, if these views be correct, is yet in its infancy. As clinical reports and other information come to light it will be found that it will assume an important position in dermatology, and many cases that have hitherto been regarded as obscure or as difficult of classification will become plain.

Chloroform a Dangerous Remedy for Tapeworm.—Dr. J. W. Carhart, of Tampasas, Tex., writes that on August 10th he administered the following prescription for tapeworm, as recommended by Dr. J. G. Brooks:

℞. Chloroform,
Ext. filic. mas. fl āā ℥ij
Emul. ol. rincini, f℥iij

M. Sig—One dose after twenty-four hours' fast.

Tne patient, a lady, very soon after taking the dose, passed through the excitement stage of anæsthesia, then suffered from nausea and vomiting. She did not get over the bad symptoms until the next day. No tapeworm was discharged, though the patient has been passing fragments for some time. Dr. Carhart has had good results with Tanret's pelletierine, and is done with chloroform.—*Med. Record.*

Diagnosis of Coccygodynia.—To detect an injury of the coccyx the index finger should be passed into the rectum, and over the coccyx. You must be careful not to be misled by the statement of the patient, for the mere insertion of the finger is a shock, and the woman at once complains before you have pressed the parts. Before manipulating the parts, ask if it gives pain; then pretend to move the bone, and see if any complaint is made, after which get directly over the bone. In real coccygodynia the slightest touch will give very great pain. This is almost as sensitive as a caruncle of the meatus urinarius.—*W. Goodell.*

A Case of Glioma Retinæ.—Dr. John L. Dickey, of Wheeling, reports, in *The Medical Journal of the Medical Sciences* for October, the history of a case of this rare form of malignant growth. He appends a summary of the literature of this subject, which shows that most gliomatous tumours originate during fœtal life, and that permanent recovery is extremely rare.

Abortive Treatment of Diphtheria.—M. Coestu (*Gazette hebdomadaire de médecine et de chirurzie*), has employed calomel in two hundred and ninety-eight cases of diphtheria, with the idea of aborting the disease. He gives daily twenty to sixty centigrammes of the drug, divided into two doses. He reports only twelve deaths under this method of treatment.

Ophthalmia Neonatorum.—Dr. Sophus Meyer at the International Congress recommended the adoption by midwives, in every case, of Crede's method of prevention. The method consists in the instillation of one or two drops of a two per cent. solution of nitrate of silver. dropping it on the cornea of the eye.

Administration of Iron.—To prevent the disturbance of the stomach occasioned by tincture of iron, it should be combined with muriate of ammonia in the proportion of one part to two of the tincture. This also renders it more palatable.

Modern Antiseptic Surgery.—Dr. Fraser C. Fuller, in the October number of *The American Journal of the Medical Sciences*, publishes an instructive article on antiseptic surgery, with illustrative cases, showing in detail the steps of an operation conducted on antiseptic principles.

Dr. James A. Reed, Superintendent of the Dixmont Insane Asylum, Pittsburg, and one of the most prominent physicians of the country, died suddenly of kidney disease on the 6th inst.

Medical Items.

At a stated meeting of the Philadelphia County Medical Society, held October 1st, resolutions approving of the appointment of a State Board of Examiners, and directing the appointment of a committee to draft a law for the creation of such a Board, were unanimously adopted.=M. Charcott has been elected a member of the French Academy of Sciences, in place of the late Baron Cloquet.=Over $7,000 have thus far been collected by *The Medical Record* for the Sims Memorial Fund.=Dr. Domingo Orvananos, the Secretary of the Board of Health of the City of Mexico, has been in New York City studying its methods of sanitary administration. =Dr. Mills succeeds Dr. Osler as Professor of Physiology in the McGill Medical College, Montreal.=Dr. Peck, of New York, has used cocaine hydrochlorate with marked success in stitching a wound of the lower lids, which cut through the conjunctiva, tarsal magin, and integument. The only sensation felt by the patient was that of the parts being pressed upon, but giving no pain.=Dr. Joseph White, of Canajoharie, N. Y., died on Oct. 27th, æt. eighty-four. He was one of the oldest physicians and was the oldest Mason in that State.= The Japanese Government has contributed $100,000 for twenty years, without interest, to a new establishment in Tokio for manufacturing pharmaceutical chemicals. =The University of Berlin has just received a legacy of $190,000, by the will of the Countess Bose, of Cassel, for the benefit of poor students of medicine.=Dr. John W. Hocking, an alumnus of the University of Maryland and a recent resident physician at the Bayview Asylum, has bought the place of the late Dr. J. Robt. Ward, at Govanstown, with the intention of practicing there.=The reception given by the Pathological Society, of Phila., to Dr. Delafield, of New York, on the 22d of October was a success. Among the invited guests were Profs. Mallett and Osler.=In Kent, England, sixty-nine persons were poisoned by, and one died from, eating shrimps which had been taken from near the mouth of a sewer=Prof. Luigi Somma, founder and director of the *Archivis de Pathologia Infantile*, a journal devoted to the study of the diseases of children, died at Naples, Sept. 19th, of cholera, in the flower of his age and in the midst of his philantrophic labors.=The *Berliner Klinische Wochenschrift* ridicules Dr. Klein's experiments on himself, which it calls his "bacillus dinner."=Prof. Finkler and Dr. Prior, of Bonn, demonstrated the bacillus of cholera nostros, at the Imperial Board of Health, in Berlin, on Sept. 23rd; and Koch admitted its striking resemblance to his comma bacillus, but reserved his final judgment concerning cultivation, etc.=According to figures given in the *Brit. Med. Journ.*, St. Bartholomew's Hospital leads the London medical schools with 138 students.=Prof. Huxley is suffering from the effects of overwork, and has gone to Venice to recuperate.=Dr. William Roberts, of Manchester, a leading authority on renal diseases, expresses a want of confidence in the newer tests for albumen in the urine, and declares that he has returned to the long-used method with heat and nitric acid.=The average duration of life in Russia is said to be only twenty-six years.=Dr. Samuel Rabbeth, the senior medical officer of the Royal Free Hospital, London, one of the most promising of the younger English physicians, died recently from diphtheria contracted by sucking a tracheotomy tube to remove an obstruction due to diphtheria.=Dr. Koch has refused the invitation to Leipsic to fill the chair left vacant by the death of Prof. Cohnheim. =Petrone (*Gazz. Med. Wol. Lomb.*, Aug. 2) inoculated twenty-four animals—cats, dogs and rabbits—under the ocular conjunctiva with the secretion and fragments of six hard chancres from patients with grave general syphilis. During more than four months no sign of syphilis appeared, nor could any be found post-mortem.=Constantine Paul uses corrosive sublimate (1 to 20,000 water) in gonorrhæa.

Original Articles.

CLINICAL NOTES.

FROM THE PRACTICE OF

H. CLINTON McSHERRY. M. D.,

Professor of Diseases of the Throat and Chest in the Baltimore Polyclinic and Post-Graduate Medical School.

PIN IN THE LARYNX.
IMPACTED MASS IN THE ŒSOPHAGUS.
NASAL POLYPI AND ASTHMA.
HYSTERICAL DIFFICULTY IN BREATHING THROUGH THE NOSE.

The first of these cases was a boy between four and five years of age, brought to me by his father, who stated that he was seen to put a pin in his mouth several hours before by his mother. She called out sharply and ran quickly to the little fellow, but on opening his mouth the pin had disappeared, and she was sure he had swallowed it. Immediately the child was taken with spasmodic coughing and grasping at the throat, which had continued until he was brought to my office.

Laryngoscopic examination showed the pin, which was of large size, placed obliquely in the larynx, with the head below resting on the right ventricular band and the point above imbedded in the posterior surface of the epiglottis near its left free border. When the child coughed the pin was drawn forwards on the ventricular band, and at every attempt to swallow the point was more firmly fixed in the epiglottis.

I anticipated some difficulty in removing it, owing to the position in which it was seen, as well as on account of the spasmodic coughing and the age of the patient, but the boy, by his good behavior, assisted me in my manipulations so much that at the first introduction of Morell Mackenzie's tube forceps I was able to catch the pin near its head, and by pushing downwards and backwards the point was disengaged from the epiglottis, then the handle of the forceps was raised upwards and backwards at the left angle of the mouth and withdrawn with the pin, point upwards, in the forceps. The child expressed immediate relief, and had no further trouble.

The second case, a British seaman, was seen at five o'clock in the afternoon at the University Hospital Dispensary, and is mentioned to call attention to an easy method by which œsophageal obstructions may sometimes be relieved.

This sailor told me that at twelve o'clock that morning he had commenced to eat hurriedly the ship's dinner, which consisted principally of stewed beef, when one of the pieces of meat suddenly passed into the gullet and produced a choking sensation and stoppage, which prevented him from swallowing anything more. He had never had any trouble of this nature before. He consulted a number of physicians, who tried to relieve him without success, and finally had applied to the gentleman who referred him to me. He said he craved water, so some was given him to test his ability to swallow, but was quickly regurgitated. There were no œsophageal forceps at the dispensary, and for that reason I tried to push the mass into the stomach, but failed, for it was so firmly fixed that when the œsophageal bougies came in contact with it, pressure as forcible as it was safe to use simply doubled them up without making any impression on the obstruction, which was situated about an inch and a half below the arytenoids. As I thought that by lubricating the œsophagus thoroughly it would be more easy to move the obstructing substance, he was directed to attempt to swallow some of the oil I had been using to grease the bougies. This he soon spat out, complaining of the rancid taste, and in a few moments there was observable a disposition to retching, which decided me to continue with the oil. He was then told to fill his throat again with it; and, while seated on a chair, to lower his head to the floor, for the purpose of letting the oil run slowly from the mouth, while, at the same time, he favored as much as possible the desire to vomit. On the fifth or sixth repetition of this proceedure he ejected, with a sigh of relief, the oil and a mass about the size and shape of a hen's egg, which, on examination, proved to be a piece of gristle with a little adherent meat, which had been compressed during the five hours it had remained in the œsophagus to the consistency of so much leather. The man at once asked for a glass of water, which he drank without difficulty and with great gusto.

So much has been said lately of reflex nasal neuroses that the third case is refer-

red to in order to impress the fact, that while reflex troubles do, in many cases, arise from nasal irritation, in making a prognosis it is well to remember that the supposed reflex condition may be only coincidental. This case, a lady, came to me from Newark, N. J., with an inability to breathe through the nose and a distressing asthma. On examination I found she had both nostrils so completely occluded by mucous polypi that all respiration was carried on through the mouth. There was no heart disease, emphysema or phthisis. The polypi were entirely removed by me with a snare, and she expressed the greatest satisfaction in being able to breathe again through the natural passage.

This operation was performed Sept., 1882, and her son, who came to consult me a few days ago, more than two years since the operation, told me that she suffered as much as she ever did from the asthma, although otherwise her health was good, and the *breathing through the nose remained perfectly free.*

Hysteria is certainly a strange condition, but a more remarkable manifestation of it I have never seen than in my fourth case. This was a girl about twenty years of age, who applied at the Polyclinic Dispensary for treatment. She said that for some months she had been obliged to keep her mouth open all the time, as it was impossible for her to breathe through the nose. No obstruction could be found, on a very careful examination of the anterior and posterior nares. Tapes were passed through the nostrils and out the mouth and then tied over the upper lip, so as to draw the velum forwards for the purpose of allowing the Polyclinic students to examine carefully the posterior nares, but no thickening could be noticed either over the turbinated bones or of the nasal septum. This latter, I may as well mention in passing, is a rare condition, I having, in ten years' laryngoscopic practice, only met with one case of a true hypertrophy of the posterior portion of the nasal septum, which occurred in a physician from Richmond, Va., who was under my care. In this instance the hypertrophy, which was considerable, took a heart shape. Of course I have frequently observed a puffiness, due to submucous infiltration, on one or both sides of the septum, near its posterior border, but that is another matter. But to return to my hysterical case. She remained under observation for several months, and thinking that she might be malingering for some purpose, frequently when examining other patients, she was kept in the room and watched both by myself and my assistant, Dr. H. M. Wilson, Jr., but she never closed her mouth. Besides giving her snuffs and irritating vapors for the purpose of making her sneeze, but without effect, on a number of occasions I held her mouth shut, when there were always evidences of want of æration of the blood and impeded circulation. Once her mouth was held closed by my friend Prof. Michael, who had seen the girl for some other hysterical condition, and after the interference in the circulation was shown by the swollen veins and darkened countenance, though there was no perceptible motion of the the alæ nasi, there was, after a time, a slight movement of a fine thread held under the nose.

These four cases not being of the every day run of practice, will, it is hoped, be found of some interest.

189 *N. Howard St.*

CROUP.

BY DR. T. V. CRANDALL, OF PHILADELPHIA.

The essential characteristics of true croup, and diphtheritic croup, have been under discussion for a number of years. The last paper, I believe, read before this Society on this subject was in November, 1875, by our popular President, Dr. Welsh. Many prominent German and English authors advocate their identity, while our best American authorities regard them as distinctive, and many medical gentlemen have expressed *positive* views in the recent issues of the medical journals against the identity of these diseases.

On seeing the annual return of deaths from croup, for 1883, at five hundred, I resolved to correspond with physicians enough to obtain reports of one hundred cases, and make a home study. Through private sources and the Board of Health Register, I obtained the names, residence, sex, age, date of death of patients; names and addresses of the attending physicians,

* Read before the Philadelphia County Medical Society, October 8th, 1884.

and report these results. My first inquiry, "Did you perform tracheotomy?"—shows fifteen cases operated on and death resulting by the disease extending downwards. Second, "Did you find diphtheritic complications?"—twenty-nine cases are reported as diphtheritic croup; seventy-one as true croup. None of the diphtheritic croup were operated on; the physicians giving as a reason, "that to operate in these cases is useless." "Was permission to operate refused?" This answer is avoided or omitted by twenty-five; twenty replies did not think it of any use to ask or to operate, as their case was too far gone when they were called; twenty-six were refused by relatives. In connection with the above investigation, I will make a few comparisons between the diseases under discussion, though familiar to you all. From 1846 when one hundred and eleven cases of true croup were reported, there was a gradual increase in deaths until 1859, when it reached three hundred and twelve. No cases of diphtheria are reported until 1860. From 1850 to 1860 there were 2,539 deaths from croup. From 1860 to 1870—3,031 deaths from croup; and in this decade 2,795 deaths from diphtheria. Since 1860 diphtheria became an established fact, giving, say, thirty per cent. of diphtheritic croup; yet there is no great increase in true croup returns above what we would expect by growth of population.

"It is difficult to estimate the number of deaths from true croup since diphtheria has made its appearance in the mortality list of the city, as many cases of diphtheritic croup have unquestionably been returned as pseudo-membranous laryngitis" (Meigs and Pepper). I lean towards the belief that many physicians losing cases of croup and believing in its identity with diphtheria, would take the benefit of the doubt, and call it diphtheritic on general principles; *i. e.*, their conclusions easily get the start of their reasoning, although we have such overwhelming proof of the distinctiveness of these diseases.

The largest weekly returns in 1883 was twenty-four deaths from croup in the week ending December 29. The first day, heavy snow, followed on the second day by rain; third day, light rain, and cloudy; fourth day, cloudy; fifth day, light rain; sixth and seventh days, clear, with the thermometer 30° to 34° above zero. This condition of humidity, with a mean temperature of 31°, and the ground covered with snow and slush, proves that cold and dampness produce croup. All writers agree that diphtheria is epidemic and contagious. "Croup is sporadic. We may produce croup in rabbits and dogs by an application of caustic to the tracheal mucous membrane, and the inspiration of hot vapor of water" (Hensch). "It is *on* this membrane that croup begins. It is *in* the mucous membrane of the pharynx that diphtheria begins as an exudation, and spreads to and into the tracheal membrane" (Flint, Bartholow, Da Costa, Day, and others). The physicians of this city, who have kindly answered my inquiries, report seventy-one cases of true croup, in a hundred, that had no diphtheritic complication, and fifty say directly, or indirectly under the head of general remarks, that they were not called early enough to do much by treatment; the immediate cause of their being called was sudden attacks of dyspnœa, etc. But how different when constitutional symptoms in diphtheria are so alarming, that before there is exudation, the physician is called to treat these symptoms, caused by specific poison.

We are unable to say that the pseudo-membrane of croup extends to or is found in the stomach, kidneys, intestines or any part except the trachea or bronchi. All authorities agree in finding diphtheritic deposits on all the above membranes, and say it may be found on any mucous membrane or abraded surface. These advocates of identity distinctly call it diphtheritic when found in the above localities, but identical with croup when it occurs on the fauces and tracheal membranes. "Truly, then, this idea of unity is drawn from coincidences. The pseudo-membrane in both, and the cynanche not always in diphtheria, but always in croup, being the principal features of the case" (Crouch). "When only the epithelium is destroyed, the fibrinous exudation lies only on the 'membrana propria' of the mucous membrane, from which it can be readily stripped off, without loss of substance. This is croupous. When the primary necrosis involves the tissue cells, as well as the epithelium, the fibrinous exudation extends from the surface *into* the tissue of the mucous membrane, and cannot be removed without loss of tissue. This form is properly diphtheritic" (Flint). There are greater pathological differences between

these diseases than between typhus and typhoid fevers, and yet we make marked distinctions, and draw the lines closely in diagnosing them.

We have seen that the cause of croup is cold and dampness. We all know diphtheria is caused by a specific poison. We find croup local, and constitutional disturbances subsequent upon the local trouble. We find the constitutional symptoms first in diphtheria. We have found croup in the larynx and trachea, and diphtheria anywhere; more frequently in the pharyngeal membrane. The most important change is found by pathologists in the blood. And here also is the greatest point of difference. A healthy child is taken ill with croup without any previous time or blood-poison to debilitate, and dies in three or four days—in a few hours, sometimes, after having played and been around the house; do you find the extensive changes in the kidney structure reported after diphtheria? We do not have endocarditis, or rapid fatty degeneration of the heart, and numerous structural changes reported in diphtheria, nor the altered condition of blood.

TRACHEOTOMY.

I am an advocate of tracheotomy. There are many physicians in this city who do not believe in it. Just in this particular the question of identity of these diseases needs to be more definitely settled. If they are identical, it is argued that to operate in diphtheria is useless. Some of the answers to my inquiries say it would be madness! Then this identity theory is mischievous, inasmuch as, if physicians do not believe in, and make themselves familiar with, the operation, they neglect the most important remedy. Prof. Von Langenbeck, of Berlin, made a study of 556 operations from 1870 to 1876. Thirty per cent. recovered, and of these 85 were on children under two years of age; the youngest seven months old (*Am. Jour. Med. Sciences*, April, 1878). Dr. Geo. Buchanan operated on 46 cases; 17 cured, 29 died; of these, true croup 16, cured 6, died 10. In diphtheritic croup, 30; cured 11, died 19 (*British Med. Jour.*, Sept. 4, 1876). Dr. Boeckel reports 22 cases and 13 recoveries (*London Med. Record*, Nov., 1880).

A physician of Strasburg operated on a child six weeks old successfully; Mr. James Bell, of Edinburgh, at six months; Mr. Tait, seven months; Dr. Greenfield, ten months; Mr. Cooper Foster, at eleven months (*Am. Jour. Med. Science*, Jan., 1881). And a larger percentage of younger children could be obtained, if the effort were made more frequently. Bayne found, in investigating 920 cases, that better results were obtained in private practice than in hospitals (*Med. News*, Aug. 2, 1884).

Is not the question, "Have any lives been saved by tracheotomy in diphtheria or croup," paramount to how many? Is not the patient fully entitled to the chance by a simple opening of the wind-pipe, which gives no constitutional surgical shock? If we are refused by parents, it is in part our own fault? The lack of confidence on our own part is quickly observed by the laity. Let a sufficiently determined and enthusiastic physician or surgeon believe he can save a child, and show it in manner, and the loving mother will soon catch the inspiration. Let him persevere, and a fair percentage of successes will reward him for his untiring energy.

I have quoted some foreign authors on statistics of tracheotomy, as we have not yet arrived at that state of perfection in gathering statistics which they have. If our Society had a record-book, and its members would agree to make annual reports on this subject, we could arrive at an approximate idea of how much this operation is resorted to in this city.

If every hospital in the city would prepare a room with the necessary apparatus, and do away with "red tape," to the extent that any physician in good standing could take his patient there and operate himself, if he wished to, putting the patient in care of a trained nurse, admitting the mother or some near relative; if some or all of the dispensaries did the same, then there would result a decrease in the death-rate of croup. At present we have some practitioners who use turpeth mineral and *never lose a case.* Others calomel, with almost like success; then there are as many known cures as there are for rheumatism, and yet a death-list of four to five hundred a year.

CASE No. 1.—I was called, December, 1875, to see Lizzie B., æt. 4 years; arrived at 8 P. M.; found child on a settee; complete apnœa existed at the moment of my arrival. The attending physicians had abandoned the case as hopeless, earlier in the

day. With the assistance of one woman, who held a lamp with a broken chimney, I then divided the skin-fat and fascia by one incision, exposed the commissure of the sterno-hyoid muscle and made an incision into the trachea. Not having any assistants to hold retractors, I separated the edges of the wound with my bent ear-forceps in my left hand, while I inserted a single canula with my right hand. This little instrument has served me in emergencies instead of one or two assistants, on several occasions, for, by inserting the forceps, closed, into the tracheal incision, I separated the walls, introduced the canula, and obviated cutting away the walls of the trachea as recommended by some authors. After the first expulsory efforts, which were very violent, the child breathed naturally, the pulse came down, full and strong. The temperature, 105°, fell, in a few hours, to 102°. On the 11th, I asked my friend, Dr. Swayzee, to assist me in removing the single canula, and inserted a double canula, he expressed serious doubts as to the child's recovery. She is now a large, healthy young girl.

Case No. 2.—December 15, 1876. J. C., age 3 years 6 months. This case of true croup I was called to, too late. The usual treatment of no avail, and apnœa almost complete. I operated with the assistance of women, and all went well until the third day, when in my absence, and in the temporary absence of a level-headed relative who had nursed my little patient faithfully, an ignorant woman in charge allowed the tube to be displaced, and before I reached the house the child had died of suffocation. I felt keenly the disappointment, as I had within my grasp another successful case.

Case No. 3.—December 14, 1877. Martha G., æt. 3 years. Diagnosis, membranous croup. In symptoms and other respects similar to Case No. 2. I treated this child with the usual remedies, including lime vapor, etc. On the 16th, at the last moment, I obtained consent of parents to operate, assisted by Dr. R. G. Stretch. The patient did well until the night of the 18th. The room was narrow and long, with a stove in the middle, and a window at one end. I placed the patient farthest from the window, but, on her own responsibility, during the night, the mother moved the crib next to the window, opened so her child could get more air. On the 19th I called my friend Dr. Stretch to see the case with me. She died of pneumonia.

Case No. 4.—February 23, 1878. Henry W., æt. 4 years 3 months, had had croupy cough, sharp and abrupt in character, with a crowing and whistling inspiration. The treatment, turpeth mineral in three-grain doses every three hours until emesis was produced; but I was alarmed at the great prostration it produced; resorted to alum, expectorant mixtures, principally ipecac, steam inhalations, and yet inspiration became more labored and was attended with violent efforts. The strength of the child being sufficient, notwithstanding the emetics (but paroxysms of dyspnœa were distressing, the child standing upright and raising the arms in the air to increase the action of the respiratory muscles). When in the last struggles, I operated, inserting a double canula. All went well until the ninth day. I had removed the canula each day after the fifth day of insertion until I was satisfied it was safe to permanently close the opening on the eighth day. On the ninth day, thinking the child well enough not to require careful nursing, the family allowed him to take a severe cold, and he died of congestion of the lungs.

Case No. 5.—Elwood D., æt. 5½ years, temperature 106°, which was reduced, and as he was in spasms when I first saw him, I waited developments, which proved to be variola. I put him in front room, third floor, with his father as nurse. A severe laryngitis set in on the seventh day of eruption, expectorants, emetics, hot fomentations to throat, lime vapor and the usual remedies, chlorate potassa and iron, failed to give relief until suffocation set in sufficiently to make his case hopeless. Unable to get a neighboring physician to assist me, I operated with the assistance of the father. I administered chloroform, and by lamplight inserted a double canula. On the seventh day I removed it and closed the wound. The boy made a good recovery, and, with the exception of some chronic conjunctivitis, is well.

Case No. 6.—December 15, 1882. Johnny C.; was called second day of the disease, and symptoms were very severe; increased rapidly, without relief by medical treatment. I sent for Dr. Ivison, who gave chloroform, and I operated. This child made a good recovery from croup, and died subsequently from another disease—heart disease, I believe, as I was not present; but

tracheotomy was a success. The child ate heartily, slept well, played, was dressed, and regarded by himself and all as well; had been discharged a week from treatment, when he suddenly and almost instantly died; but as a post-mortem was refused, I never knew the cause.

Case No. 7.—January 17, 1883. Alfred P., æt. 3 years 9 months, presented same symptoms as Case No. 1, and on the third day was considered hopeless, unless tracheotomy could save him. The surroundings were not inviting; the only room available was a large one, with a door opening into the street; this was nailed up, and admission gained from the rear of the house. I operated on this child, and although I nearly lost him several times, by the canula closing with loose fragments of pseudo-membrane, by careful nursing and close personal attention, I was successful in this case. I used a mixture of one drachm of acid phosphoric dilutum to six drachms of glycerine, as a solvent of the membrane which formed below the opening. This mixture was more successful as a solvent than any I had ever used. I am indebted to Dr. Pepper for the suggestion of its use in diphtheria.

I now read Dr. J. F. Stone's account of

Case No. 8.—Mabel S., æt. 3 years. A beautiful, healthy child, with a previously good history. After complaining of throat trouble for two or three days, was seen by Dr. J. F. Stone, and on examination no exudation, but swollen, red tonsils. May 3, slight fever and huskiness of voice. On the morning of the 4th, a remission of unpleasant symptoms, only to recur more decidedly in the evening. The 5th gave the same, but more severe, and so rapidly did the evidences of suffocation increase, that it became evident that a fatal result must ensue, unless relief could be had. Dr. Crandall, who had seen the case on the previous day in consultation, was again summoned, and concurred in the decision that the only hope for prolonging life lay in the immediate performance of tracheotomy, which he did. The immediate results were truly gratifying to all, and were followed by care and watchfulness unsurpassed, which resulted in recovery.

I will state that when I was first sent for, I advised to try medical remedies further, and postpone tracheotomy, thinking that Dr. Stone could cure the case by that means. After twenty-four hours of close application, the patient grew alarmingly worse, and we administered chloroform and operated. This case resisted the the closing of the wound. On the fifth day, and thereafter, each effort to close the opening was accompanied by dyspnœa and gradual granulation seemed to be the best method. I will ask Dr. Stone to detail the peculiar features of this case.

In my treatment of croup, and after-treatment of tracheotomy, I have concluded it is not best to canopy a bed, or place a child in a small room. The temperature is too suddenly changed, the air is quickly vitiated, the child needing all the oxygen it can get, is deprived of it. I observed in No. 1 case, when I ordered a piece of unslaked lime to be put in a pan on the stove, the father did it in true Irish style, by putting a bucket of lime in the wash-boiler. The effect on the patient was salutary, thinning the discharge from the canula. I used local lime-water spray, with a Codman & Shurtliff Steam Atomizer at intervals of half an hour. Leaving out of the question laryngotomy and laryngo-tracheotomy, I simply did tracheotomy, cutting as low as the third ring. The inferior thyroid vein must be pushed aside. There is no necessity to do much cutting after the skin and fascia are divided. The thyroid gland was removed in part in two of my successful cases.

Society Reports.

PROCEEDINGS OF THE MEDICAL SOCIETY, DISTRICT OF COLUMBIA.

STATED MEETING HELD OCT. 15TH, 1884.

(*Specially reported for the Maryland Medical Journal.*)

The Society met with the President, Dr. Garnett, in the chair, Dr. McArdle, Secretary.

Dr. Hartigan presented A Rupture of the Spleen. The patient, he said, was a colored man, about 30 years old, who died suddenly under suspicious circumstances. It was charged by his neighbors that his whiskey had been drugged; but Dr. Hartigan thought he had been suffering from acute malaria, having been confined to his

house for some time, the spleen being about three times the normal size, and that the rupture was due to a fall whilst under the influence of whiskey, or else was caused by the strain of vomiting.

Dr. Hartigan also presented A RUPTURE OF THE HEART. The patient, an inmate of the Soldiers' Home, was found dead in a water-closet of that institution. The pericardium was distended with blood to its utmost capacity. Calcification of the aorta was present also, and there was an extensive rupture of the left ventricle supposed to have taken place during the efforts at defecation. The heart presented the appearance of fatty degeneration.

Dr. Bulkley said he had, a very short time since, been called to a case of malarial poisoning of unusual intensity for this locality. Dr. Lincoln saw the case with him in consultation. The man suffered with extreme irritability of stomach; nothing would remain on his stomach, not even small doses of iced champagne, the vomiting was almost incessant. Finally, after vainly endeavoring to quiet the gastric irritation; the febrile paroxysms continuing with increased violence, and the patient's life being endangered by their long continuance and from irritation and want of rest, it was concluded to try quinine hypodermically. The formula used was one used by a Virginia medical man and given by him in an article published in one of the medical journals last year. It was quinine ʒss; tartaric acid, grs. xv; water, ℥ ss; to which it was found necessary to add a small quantity of glycerine and filter to make a clear solution. The dose of this given was twenty minims, to be repeated every two hours if necessary; but only two injections were given, as the first checked the chills and stopped the irritability of the stomach. The case made a good recovery.

The only objection, said Dr. Bulkley, to the use of quinine in this way was the injury to the hypodermic needles; it blackened and corroded them so that after a few times using they were spoiled. The solution did not produce any undue irritation at the point of insertion. The patient did not complain of its giving him any pain, but on the contrary asked to have the injection repeated, so impressed was he with its beneficial results. The effect of quinine hypodermically in this case was so entirely satisfactory, and it fulfilled every indication so completely, that the doctor said he would resort to it promptly in the future in similar cases, and would recommend to the profession its trial in all cases where the drug was not well borne by the stomach, and where its administration was of such vital importance, as in the case narrated.

Dr. J. Taber Johnson presented A UTERUS, from which most serious hemorrhage had been occurring during the last four or five years. These hemorrhages were supposed to be due to change of life, and the fact that they occurred about the time of the monthly periods seemed to give color to this supposition. As they kept up for so long a time cancer was suspected, but no thorough examination was made. Dr. Johnson first saw her three or four weeks ago. She had not then for several days dared to turn over in bed, which was found to be covered with blood. He inserted a tampon saturated with a solution of alum and packed the vagina tightly. In a few days she got out of bed and went around, but in two weeks another hemorrhage set in and he again tamponed. She was, however, seized with a chill; her left leg swelled as large as her body, and she died suddenly. Dr. Johnson thought she suffered successively from phlebitis, pulmonary thrombosis and heart-clot. In examining the uterus he could find nothing to which he could attribute the hemorrhage. There was an ovarian cyst on one side and a ruptured ovarian cyst on the other.

The specimen was referred to the Microscopical Committee.

Dr. Smith presented a specimen of CANCER OF THE UTERUS with the following history: Was called to see the patient about the first of the present year. She had then been an invalid about six months. On examination he found extensive disease of the cervix, and was able to pass his finger into the body of the uterus with facility. A large portion of the cervix felt as though it would break off if any force was applied. Some weeks after, the disease invaded the bladder, producing a fistulous opening through which the urine escaped. Whenever this opening become obstructed, the patient experienced great pain. Obstinate constipation was the next symptom to occur, the patient going sometimes as long as six weeks without defecating. Towards the end of life the patient found it necessary to use the hand to remove the scy-

balous masses that filled the rectum.

The autopsy disclosed extensive disease of the uterus. The cervix and a large portion of the body of the uterus had been destroyed. Secondary foci were found in the pancreas and spleen. The kidneys were very small.

Dr. Smith also gave the history of the case from whom he had removed the specimen presented last week. The patient is a widow, 35 years old, the mother of eight children. About two months ago she consulted Dr. Smith for a profuse and offensive purulent discharge from the vagina. On examination, an eroded condition of the cervix was found and applications made thereto. At the following menstrual period an excessive flow took place requiring the tampon to stop it. After this ceased, an oblong growth about an inch in its long diameter, was found within the cervical canal, on the posterior lip of the cervix, which bled freely on being touched. Applications of nitric acid and saturated solution of chromic acid failed to remove this excresence, and, fearing that it was malignant, it was removed with scissors and the sharp curette, and a tampon saturated with chloride of zinc solution applied within the cervical cavity. The vagina was tamponed with cotton saturated with a solution of bicarbonate of sodium. No hemorrhage followed the operation.

Dr. Smith believed that all suspicious growths of the cervix uteri should be removed, as it gave the patient the best chance of recovery if they proved to be malignant; and if the microscope showed them to be benign, no harm was done by removing them.

On motion of *Dr. J. Ford Thompson*, the subject of CANCER OF THE UTERUS was set for discussion at the next meeting, and the Committee on Microscopy was requested to report by that time on the specimens of diseased uteri submitted, and referred to said committee.

On motion, the meeting then adjourned.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

STATED MEELING HELD OCT. 8TH, 1884.

DISCUSSION ON CROUP.

Reported by G. BETTON MASSEY, M. D.

Dr. F. Crandall read a paper on CROUP.*

Dr. J. Solis Cohen, in opening the discussion, said: The principal impression gained from this paper is the importance of tracheotomy. As regards the identity of these diseases, while I contend that there is a difference, I am not prepared to recognize so great a difference as is claimed by the reader of the paper. Croup and diphtheria do not present in the alleged proportionate frequency. True membranous croup is a very rare disease, and that is the reason so many disbelieve its existence. The series of successful tracheotomies, reported by Dr. Crandall, is very remarkable, and I trust that in future his success may continue to be as great. It is certainly greater than any that has been reported in this or any other city probably in the United States. Some years ago (1873), I prepared a paper for this Society, in which the results of more than five thousand cases were given. The proportion of successful operations was about one in four. Before that paper was presented, operations had been rare in Philadelphia; since then they have been become more frequent. The ratio of success is not always maintained in one's later experience. Thus the late Dr. Hodge, who at one time reported four cases, three of which recovered, told me that he had subsequently operated seven times in succession without another recovery. Dr. Jacobi, whose success had been exceptionally good at one time, informed me some years afterwards that he had been so unfortunate as to lose one hundred cases in succession, and thus his early confidence in tracheotomy has been modified.

The reason for this variation of results is, I think, plain. We are careful of our first cases. We see them frequently after operation, just as the writer of the paper has done. When we become older, this time is not at our disposal. The after-nursing I regard as of the very highest importance, and I have long made it a rule never to operate unless sure that this will be properly attended to. The time for operation is a question of great moment. The best rule is to operate as soon as the thought of the necessity comes into your mind. Success depends on early operation, other things being equal. The tube appears to me to be a necessity. To dispense with it I regard as dangerous, notwithstanding it is thought by some to produce irritation, and thus favor the deposit of new

* See page 32 of this Journal.

membrane. A few years ago, impressed with the encomiums of Dr. Martin, of Boston, I adopted the plan of keeping the edges apart by ligature without a tube; but inattention in nursing allowed the opening to become so frequently occluded by the soft parts, in the motions of the child, and suffocation, fortunately overcome at the moment, having ensued on one occasion, I have felt no desire to repeat the experiment.

Steam in the room, and the maintenance of an equability of temperature, are important. If I had two things to depend upon in croup, I would choose vapors from slaking lime. But a small piece in a pan of water upon the stove, will not answer. Copious disengagement of vapor is needed, just such as was produced by the ignorant Irishman mentioned in the paper. I have no notion that the action of the lime is chemical, although I am aware of its slow action on membrane in a test tube. I believe that it acts mechanically. Small particles of lime are carried up with the vapor of water; these get under the false membrane which does not everywhere hug the tissues closely, and act as minute wedges; the accompanying vapor of water follows and detaches the products.

I believe that I have seen life saved more frequently by lime used in this manner than by tracheotomy. Dr. Crandall has been fortunate in braving the contingencies that surround some of his cases. There are very few men brave enough to operate without adequate assistance, and with the light furnished by an uncertain lamp. Anomalous blood-vessels often give unexpected trouble.

As regards the point of incision, my own plan has been to perform the low operation—that is the one below the isthmus of the thyroid gland. A larger tube can be inserted there, and the wound is further from the seat of the disease. It is true this is the more difficult operation, but there is no occasion for a hurry, unless immediate death is threatening. The ten or fifteen additional minutes required for a deliberate operation, steal nothing from the patient's chance of life. In an emergency, of course there is no choice. All the tissues may have to be incised in one cut. Another fact rendering the lower operation more favorable, is the lessened liability of coming directly upon masses of pseudo-membrane, which may be forced down the trachea in the very act of incising it.

An important point, too, not appreciated by the majority of operators, is that this false membrane is a foreign body, and should be removed. The first thing to be done after the trachea is opened, is not to put in the tube, but to make a thorough search for false membrane, and to remove all within reach. Then the edges of the cut should be kept asunder and cough be excited to drive more out. If this were done more frequently, the statistics of recovery from the operation would be much more favorable.

We sometimes have hemorrhage to deal with. The best method to treat this is to plug the wound about the tube with absorbent cotton. Never hunt for the vessels; pressure gives the best results. The character of the tube is important; these are often found made of hard rubber, but I do not consider such material desirable. It is thicker than silver, thereby lessening the calibre, and does not tarnish when the wound goes wrong; and this latter characteristic of silver tubes is frequently of service. The tube should be of equal calibre throughout, and not made tapering, so that the patient may get all the air he is supposed to get.

[In answer to an inquiry from Dr. H. R. Wharton as to his use of chloroform, Dr. Cohen replied that the operation was made easier by anæsthetics, but the safest plan is not to use them. Ether is out of the question, if ordinary artificial light be close. The patients were usually numb and insensible from impending carbonic-acid poisoning, and when retaining sensibility often seem to understand the purpose of the operation, and do not struggle. Struggling should be prevented by wrapping the trunk and limbs in a sheet or a towel.]

Dr. H. R. Whrrton: I agree with Dr. Cohen that the results of Dr. Crandall's operations have been remarkably successful. The results of my own cases have been fairly encouraging.

As to the two diseases under consideration, I am opposed to the use of an anæsthetic in the operation of tracheotomy, and believe that I have seen two cases lost through its use. The after-treatment of cases of tracheotomy, when performed for croup or diphtheritic croup, is most important, and I consider a moist atmosphere

very important in these cases. At the Children's Hospital, in this city, we have a room especially fitted up for tracheotomy cases, which can be readily filled with the vapor of steam from steam-heating pipes. The permanent removal of the tracheotomy tube has, in my experience, often been a matter of greater difficulty than its original introduction. I recently had a case in which the tube was removed on the thirteenth day; the condition of the patient was good, the temperature and pulse being normal. An attack of dyspnœa supervened two hours after the removal of the tube; the gentleman left in attendance was unable to re-introduce it, and when I arrived the child was dead. I have performed tracheotomy five times for diphtheritic croup, with two recoveries; one of the fatal cases was the one just alluded to, which died on the thirteenth day after the operation, from an accidental cause.

Dr. J. M. Barton: I regret that Dr. Cohen has not given a more definite rule "when to operate" than "when you begin to think of tracheotomy then is the time to do it." As soon as you make a diagnosis, and perhaps before you make a diagnosis of membranous croup, you think of tracheotomy. I was called in two cases lately by recent graduates to perform tracheotomy in croup. Doctors, parents and friends were all urgent for immediate operation; they were evidently under the impression, that without operation certain death, with operation instant recovery; the cases were not urgent, they both had croup, but there was no important obstruction to respiration; under careful treatment, which had been neglected, they both recovered without tracheotomy. My own rule has been, when the tissues just above and just below the sternum decidedly recede during inspiration, when the face becomes slightly livid and the respiration hurried, with the usual symptoms of croup, the time to operate has arrived.

I have not found ligatures of much use in keeping the wound in the trachea open. In operating low down in a young child, with small and deep trachea, the ligatures pull directly towards the surface. A probe bent into a circle and a hook fashioned on each extremity, will keep the wound open by its spring, until a properly fitting tube can be obtained.

Is it desirable to operate *in extremis?* I have operated on several such cases, in which artificial respiration had restored them, but they all perished in from one to three days.

Dr. Nancrede: I have been much interested in the excellent paper read by Dr. Crandall, but dissent from the evident impression intended to be conveyed by the writer, that tracheotomy is a trivial operation, and one which may be undertaken without any hesitation. I am not ashamed to rank myself with those surgeons who dislike such operations, especially when so bold a one as Billroth says that he blames no surgeon for declining to perform laryngotomy on a young child. This may seem exaggerated language, but although in the majority of cases the operation is a simple one, yet it may demand all the surgical skill and nerve that the surgeon is possessed of, as in the last tracheotomy I performed. Two cases have been related this evening, in which death occurred during the operation by most competent operators. Billroth has had a similar experience, and I know of a number of others.

An otherwise good, general practitioner, with a previous hospital experience, sent for me on one occasion saying that he had opened the trachea, but could not introduce a tube. Upon examination I discovered that he had sliced off a portion of the right ala of the thyroid cartilage, but had failed to open the trachea at all. Other operators had cut either the normally or abnormally placed carotid artery, or had dissected between the trachea and the carotid artery until they had reached the vertebræ. Other accidents have also happened, which should make us pause, while we recall the fact to mind that if we do not get through the operation successfully, we kill our patient. I cannot resist the impression which my experience has produced, that diphtheria and pseudo-membranous croup are identical diseases, modified by their locality, rapidity of progress, etc. Diphtheria is said to be distinguished from croup by the presence of albuminuria, but German investigators have shown that albuminuria exists in a distinct proportion of cases of so-called croup. Besides most croup cases *die* before this symptom can make its appearance. Moreover, all cases of undoubted diphtheria do not present at first, or at any time, those profound alterations of the blood, and the kidney

lesions which result in albuminuria.

Finally, whether the diseases are identical or not, clinically it was generally impossible to distinguish them at the time of operation. I may refer to a series of cases in my own practice, which would have been decided by any member present as typical cases of true croup, which yet by their subsequent course—even diphtheritic paralysis—or their marked contagiousness, proved to be undoubtedly diphtheria. The difference in character of the false membrane in the pharynx, larynx and trachea seems to be relied upon by some of the speakers as a proof of the essential difference of the two diseases. Precisely similar conditions are found in undoubted diphtheria, and are explainable on anatomical grounds, so that the membrane of croup and the membrane found in the trachea in undoubted diphtheria are identical in appearance, etc., being in the substance of the mucous membrane *in the pharynx*, but upon its surface in the trachea. There are many other similarities, but time does not permit them to be referred to.

As to when to operate, croup cases are divisible into two groups, viz.: those in which the dyspnœa is subject to violent exacerbations, but is slight during the intermission; and those which steadily increase, each paroxysm being succeeded by a relative intermission only, the dyspnœa steadily increasing. In the first class of cases, the patient may, it is true, die in an access of dyspnœa, but there is time to try medical measures usually. In the second class, when there is marked depression of the epigastrium and base of the chest, and also of the episternal and supraclavicular fossæ, despite the persistent use of the admirable treatment suggested by Dr. Cohen, operate at once.

Personally, I prefer to operate without ether, although it is harder for the operator, unless the patient has become insensible from carbonic-acid poisoning.

The fenestræ generally found in the tubes I regard as ridiculous. They are generally to be found outside the trachea when the tube is in place.

There should be no hurry in doing tracheotomy. Both hurry and force are exceedingly dangerous, and kill the patient sometimes. A hurried operator may force down the membrane before the tube; the trachea, being more resistant, may be cut, while the membrane will give before the knife, if the latter has been dulled. Some form of dilution had better be used to permit the removal of loose membrane, etc.

[Subsequently, Dr. Nancrede said, in answer to Dr. Stewart: I am aware that diphtheria is a disease of asthenic character, but I deny that it always commences as such, especially in the larynx, and inquiry will often develop the fact that there has been an attack of pharyngeal diphtheria precedent to the croup.]

Dr. W. S. Stewart: I have been very much interested in hearing the discussion this evening. I remember hearing a paper read before this Society some time ago, in which the necessity of early operation in croup was urged. But the reader of that paper, when interrogated as to his success in his operation, had not had one recovery. In the paper of this evening there is a large proportion of recoveries. The contrast between the two papers reminds me of a little experience when I went with a brother physician, who had a subject, as he thought, necessitating an operation as a dernier resort for croup; when the parent of the child refused to permit the operation, as soon as the arrangements would be made; and so fickle-minded was he, that three unsuccessful attempts were made to perform tracheotomy during an interval of two days, and still the child recovered without the operation. The difficult problem to solve is, the mortality that would result from not operating and the actual lives saved by operating.

I have no hesitation in maintaining that croup and diphtheria are distinct diseases.

I confess I have not had the experience of the last speaker in seeing a case of diphtheria develop and terminate fatally in a few hours. And I could not account for such results, except in the fact of it being an insidious development, and in its asthenic nature giving no special symptoms for a certain interval of time at first, except the feeling of languor and an unaccountable sensation of lassitude. Croup, on the other hand, is a sthenic disease; is ushered in suddenly, and is always accompanied by a cough of a peculiar and characteristic sound. The membrane of croup is lighter in color than diphtheria—lies more on the surface of the fauces and trachea, and is more readily expelled by coughing; whilst

the germs which enter into the formation of the diphtheritic membrane imbed themselves into the tissue, and are of dusky hue, it is with greater difficulty removed, and is not accompanied by a cough.

Dr. Jas. F. Stone: There is one point that I would like to emphasize, and that is, the vital importance of attending the patient carefully after the operation. I am one of those who believe in the necessity and very great advantage of this operation, and in its early performance; and yet I do not believe it should be performed, unless the physician will devote a proper proportion of his time to the after-treatment. When we consider that the operation is of a character that does not relieve the physician of his responsibility, but even makes it greater, we should be willing to devote days, and possibly weeks, to its proper performance.

Dr. Sajous: In a case which I saw today operated upon by myself two weeks ago, I noticed that a peculiar odor accompanied each expiration, and upon examination found a spot of ulceration just opposite the fenestra (this being rather low down near the tracheal aperture of the instrument), upon the posterior wall of the trachea. I consider the fenestra as useless. The distance between the tube in situ and the wall of the trachea, is sufficient for the passage of air, and when the voice can be used, the tube does not offer enough interference to prevent the formation of the voice.

Dr. Formad: As to the misconception between croup and diphtheria; some gentlemen have expressed an opinion that there are different pathological processes in the two. Pathologists never asserted that the two diseases are clinically identical, but only that the pathological process is identical. If the product is different, it depends on the locality affected. We may have a urethritis or a cystitis; the diseases are different, and the symptoms different, but the pathological process is identical. It is nowhere said, in text-books of pathological anatomy, that croup and diphtheria are clinically, or even anatomically, the same.

In diphtheritic angina, the deposit is deeply seated, because the inflammatory exudate cannot get outside on account of the anatomical construction of the mucous membrane of the pharynx. In the larynx and trachea the exudate cannot stay below, it being expelled by the elastic tissue of the mucous membrane, which, moreover, has but one layer of an easily permeable epithelium. The exudate is bound to get out as soon as formed. We may have similar exudates on any surface of the body; in each case the deposits differing with the local conditions. Virchow has well expressed these differences: Diphtheria is "Eine Einlagerung," croup is "Eine Auflagerung" of the exudate.

In croup, the absence of constitutional symptoms is easily explained. While in diphtheritic angina the deposit is imbeded into tissues rich in lymphatics and blood-vessels, and death ensues usually from absorption of septic materials; in croup, the deposit lies on the outside of the body; death may ensue from stenosis of the larynx or trachea, but not from absorption of septic materials, as there are but few blood-vessels and lymphatics in this situation. The anatomical difference fully justifies a clinical differentiation. The deposit of the exudate is like a nail which may lie on the surface, or may be driven into the wood. The nail is the same in each case, but is under different conditions and has different effects.

Dr. Crandall, in closing the discussion, said: Dr. Cohen has referred to Dr. Jacobi's low percentage of cures latterly. Dr. Jacobi doubtless operated as scientifically and skilfully in his later as in former cases. So also does Dr. Levis. Yet he reports many failures. I do not lay claim to great scientific accuracy, but wish to demonstrate the importance of after-treatment. The children averaged from three to four years of age, and this made it easier of performance in the cases given. I saw one of these cases every two hours, the other every four or five hours, and believe success due to this. I also believe that physicians should be able to perform this operation whenever called upon. I am under many obligations to those who have assisted me, this evening, in establishing the differential characters of these diseases.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD OCT. 17, 1884.

Dr. B. B. Browne, the newly-elected President, called the Society to order at

8:30 P. M. After which he addressed the members as follows:

THE PRESIDENT'S ADDRESS.

Members of the Clinical Society:

I cannot let the present opportunity pass without rising to thank you for the honor which you so unexpectedly, but unanimously, conferred upon me at your last meeting, which no one among you had less right to expect than myself. When I look back over the names of my predecessors in this chair, I feel embarrassed at being called upon to fill the place which has been occupied so worthily by them. To preside over this Society which has done so much good work and which is unanimously conceded to be the *working* Medical Society of Baltimore, is no empty honor. Failing in in words to express fully my estimation of your kindness, I can only show my appreciation by an earnest effort to perform the duties of the office so as to secure for our meetings the most efficient work. This Society, from the time of its organization, has been one of steady growth, and is now the largest and most prosperous local Medical Society in the State, and for the character and amount of work done will compare favorably with any similar Society in the Country. The papers read and the discussions on them have increased in excellence from year to year, pathological specimens in great abundance have been exhibited, many of them rare and unique in character and for the most part exceedingly instructive. I hope that the present year may be one of success, and for this I rely upon your kind aid and hearty coöperation.

Dr. R. Winslow read the first paper of the evening, entitled "A Case of Procedentia Uteri Treated by Shortening the Round Ligaments with Kæpho-perineorraphy." The doctor said, upon assuming charge of Bay View Surgical Department, his attention was called to a woman suffering from prolapsus uteri, all the means tried for retaining the organ in position having failed. As far as could be ascertained, she was married and the mother of one child, she is about 40 years of age, still menstruates, is quite active and has had her present trouble for six months with the usual symptoms. Some weeks after his services began, the patient had prolapsus of the rectum with threatened gangrene of the bowel, all the coats of which protruded, it was reduced and the rectum tamponed with cotton saturated with glycerine and tannin; this trouble did not again return during the term of service. All attempts having failed to keep the uterus in position, "I decided to attempt the shortening of the ligaments by an operation. On September 11th she was put under chloroform; upon examination the heavy, enlarged uterus was found protruding between the thighs, the os was somewhat everted, eroded and very red, the cavity of the uterus was four and a half inches long, the vaginal walls dry and hard as skin. The parts were returned and the vulva, pubes, and lower portion of abdomen irrigated with a solution of bichloride, 1 to 1,000. An incision two inches long was made over external abdominal rings which were exposed, the extremity of ligament seized and drawn upon with force until the fibrous cord was shortened on one side about an inch and the other more. The ligaments having been drawn upon until strong resistance was experienced were stitched into the rings; sublimated silk was employed for the sutures and the ends were cut short. The incisions were united by suture, dressed with iodoform and absorbent cotton, with rapid union as a result. The vagina was plugged with cotton saturated with glycerine and tannin. The orifice of the vagina being dilated and a slight rupture of the perinæum existing, the former was narrowed and the latter restored in order that the ligaments might have the best possible conditions for nsefulness; this was done one week after first operation, at which time the incisions had nearly healed and the uterus was high up in the vagina. After the second operation, in spite of the patient being unruly and getting out of bed several times, no reaction followed. Warm vaginal injections were used while the patient was in bed. October 6th she was allowed to sit up for the first time.

The doctor spoke highly of aseptic silk, and of the advantages gained by painting the incisions with iodoform-collodion. He thought that owiug to his neglect to empty the bladder the ligaments were not shortened as much as they might have been.

DISCUSSION.

Dr. Chunn thought the operation one that all should try in similar cases as

the reported results were favorable.

Dr. Erich said the principle good from the operation would come from the tendency of the shortened ligament to keep the fundus forwards and throwing the cervix into the hollow of the sacrum.

Dr. Tiffany thought that shortening the ligaments but an inch or an inch and a half in a case where the uterus had been lying between the thighs, as in this case, would fail to bring the fundus within several inches of its natural position.

Dr. W. J. Jones read the second paper of the evening, upon TUBERCULOSIS OF THE UTERUS. Dr. Jones said the purposes of the paper was to call attention to a form of uterine diseases which, though rare, had not met with the recognition it deserved. Two such cases had been seen at Bay View.

CASE I.—F. G. white, age 40, nullipara. Autopsy showed advanced tuberculosis of both lungs, tuberculous ulcers of ilium, miliary tubercles in liver and spleen, and a few in peritoneum; uterus small and flexed toward left side. On its posterior surface, and at the fundus immediately beneath the peritoneum, were two myomæ as large as peas. The uterine cavity was small and contained a small amount of caseous pus; the entire fundus was covered with a superficial ulceration, in which numerous whitish points could be made out. The distal ends of the fallopian tubes were much dilated, and, upon being squeezed, a thick pus was discharged; the left tube was twisted. Both ovaries were rough and contracted and of a dense fibrous consistency. The caseous matter in uterus and tubes showed abundant tubercle bacilli. Upon section the ulcer of uterus showed tubercular inflammation of the mucous membrane. In most places the mucous membrane was wanting, its place being occupied by a dense small celled infiltration, which speedily became caseous.

CASE II.—M. D., colored, age 26, nullipara. Autopsy revealed same conditions as in Case 1, except as regards the ilium; miliary tubercles were numerous in Douglas *cul-de-sac*. Uterus small and ulcerated on its entire inner surface; its cavity contained caseous pus. The fallopian tubes were enlarged and convoluted, the convolutions in many places adherent; dry, tough caseous matter was found within them. The microscope revealed a caseous inflammation in the body of uterus and miliary tubercles in the submucous tissue. Bacilli were found in the pus from both the tubes and uterus.

CASE III.—This is the uterus of a woman 28 years old, who had several children, her last gestation being five months before her death from general tuberculosis. The uterus was normal in size and had a superficial ulcer at the fundus covered with a caseous mass. The fallopian tubes were thickened and distended with caseous material. The ulcer showed miliary tubercles in the tissue beneath. The doctor followed these cases by quoting from a number of authors showing the frequency of the affection. He thought tuberculosis of the uterus seldom a primary trouble, and that it was almost always associated with tubercular salpiryitis, to which it is secondary, as the result of direct infection of the mucous membrane from the tubercular virus in the tubes. Cases may occur from a general infection of the blood with the bacilli; the ordinary course is for tuberculosis of the tubes to follow that of the peritoneum, and then the uterus. Coitus may also carry the infection in cases were the seminal fluid contains bacilli from a tuberculous condition of the prostate or seminal vesicles. The seat of the affection in the uterus seems to be almost always in the body; it takes the form of an ulcerative process, and this may extend to the cervix, or even into the vagina. The disease may be strongly suspected if a patient be tuberculous with a persistent leucorrhœa and other uterine troubles; should caseous masses be expelled from the uterus, the opinion will be strengthened; but the most certain and positive test is the presence of the bacilli in the secretions. Should the disease be recognized, the usual treatment for tuberculosis should be instituted, with possibly the topical application of iodoform.

Dr. W. B. Platt showed specimens of rubber adhesive plaster; also Prof. Holtzman's instruments for the treatment of genito-urinary diseases, and described the inventor's method of using them.

Dr. W. P. Chunn exhibited a specimen of what appeared to be a deciduous membrane.

Prof. Hermann, of Zurich, has been transferred to the Chair of Physiology at Königsberg, succeeding Prof. von Wittich.

Editorial.

HARVEY'S FORECASTS OF GREAT MODERN DISCOVERIES.—In the Harveian oration for the present year, delivered before the College of Physicians of London, October 17th, Dr. J. Russell Reynolds enters into a somewhat critical review of the writings of Harvey in order to show that this great physiologist foresaw many things which modern science has only comparatively recently revealed to us. Among these are the doctrines of protoplasm, of vaso-motor nerves, of reflex actions, and of the germ theory. In proof of this statement numerous quotations are made from the writings of Harvey. Among the references considered as applicable to the doctrine of protoplasm, the following is very striking: "All living things derive their origin from a certain primary something or primordium, which contains within itself both the 'matter' and the 'efficient cause'; and so is, in fact, the matter out of which, and that by which, whatsoever is produced, is made." The vaso-motor system is supposed to be foreshadowed in the following: "We allow to the arteries the same motions that we concede to the heart, viz: a diastole and a systole or return from the distended to the natural state; this much we believe to be effected by a power inherent in the coats themselves." In alluding to what we now call reflex action Harvey says there are "some actions and motions the government or direction of which is not dependent on the brain"; he refers this to a "natural sense" (in contradistinction to the "animal sense"), and says that this natural sense is observed in zoophytes or plant-animals, in sponges, in the sensitive plant, in the decapitated hen, and in the embryo, as well as in ourselves. He adduces the action of the lungs in respiration, coughing and sneezing as of this nature. Of the exact site of this sense Harvey is left only to conjecture. Instead of referring it to the spinal cord, he attributes it to the heart. One of the most interesting, however, of the previsions of Harvey is that relating to the germ theory. He writes of the "manner in which epidemic, contagious and pestilential diseases scatter their seeds, and are propagated to a distance through the air, or by some 'fomes' producing diseases like themselves, in bodies of a different nature, and in a hidden fashion silently multiplying themselves by a kind of generation, until they become so fatal, and with the permission of the Deity, spread destruction far and wide among man and beast." Nothing would seem to describe more accurately our present views with reference to the causation and mode of propagation of epidemics than these words.

Remarkable, however, as the above observations may appear to us, living at an interval of over 230 years since they were made, we can hardly consider them more than vague theories or glimpses at the truth; for if their true import had been appreciated, we cannot imagine for a moment that the genius of Harvey would not have seized upon them, and with the pertinacity of conviction forced them upon the attention and acceptance of his incredulous contemporaries. For it is thus that great discoverers have acted, throughout the history of the world.

There is one lesson which the study of the character and writings of Harvey suggest, and upon this the orator lays due stress. It is that he was always studying and seeking to interpret *nature*. He was "one of her keenest and most devout interpreters; in reverence he knelt before her, and asked her questions; he cross-examined her, but in no unfriendly tone. Nature to him was a perfect verity, the one witness that could never be absorbed or shaken, the one witness in whom there could be no false way, the one witness who could not lie. And by such a method only must science ever be advanced; it is thus that great discoveries are to be achieved, thus that we must seek to leave our "footsteps on the sands of Time."

SIR JOSEPH LISTER ON CORROSIVE SUBLIMATE IN ANTISEPTIC SURGERY.—Sir Joseph Lister is not one of those contracted minds who feel bound to defend a view once enunciated merely for the sake of consistency or for fear of the accusation of having "been wrong." He believes in the growth of knowledge and the development of a principle. We find him, therefore, still introducing improvements into his antiseptic treatment which, despite opposition and ridicule, has steadily grown in the estimation of the profession throughout the civilized world, His latest contribution to the subject was that upon "Corrosive Sublimate as a Surgical dressing," delivered be-

fore the opening meeting of the Medical Society of London, on the 20th ult. This address, which is well worthy of reproduction entire, details how the author had lately observed unexpected suppuration after several of his recent operations, and in one case—a scirrhous mamma—a fatal septicæmia. These occurrences were so unusual in his experience that he investigated the subject with great care, and as the result, found the fault to lie in his eucalyptus gauze, which, as is well known, he has of late years substituted for his former carbolic acid dressings. It was ascertained that in the manufacture of the gauze the eucalyptus oil became volatilized to such an extent that it was no longer present in sufficient quantity to produce complete asepsis in the wounds. Carbolic acid, whilst perfectly trustworthy as an antiseptic, is also volatile, and is open to the same objections on the score of imperfect manufacture. Quite naturally, under these circumstances, Prof. L. turned his attention to the corrosive sublimate—a non-volatile substance—which Koch had several years before ascertained to be the most powerful of this class of agents. The irritating and poisonous qualities of this drug offered obstacles which had, however, to be met. Experiments were instituted with a view to mitigating these objectionable properties; the result was that it was found that when combined with albumen a mixture results which is measurably deprived of the irritating effects of the drug. The form of albumen employed was serum (that derived by stirring horse's blood while undergoing coagulation was employed with the experiments), and the gauze was soaked in a sublimate solution of this, of such strength that the gauze contained a 2 to 4 per cent. by weight of sublimate. This was non-irritating, yet perfectly antiseptic. Although Sir Joseph adduces some cases in which the proposed gauze was employed with very satisfactory results, he acknowledges that the test of practical application still remains to be made.

Further examination of the claims put forward in behalf of Prof. Pacini, of Naples, as the discoverer of the cholera bacillus of Koch show that they are unfounded, the microbi described by Pacini being entirely different from the comma bacillus.

Book Notices and Reviews.

Diseases of the Oesophagus, Nose and Nasopharynx. By Morell Mackenzie, M. D., of London. American Edition. Philadelphia, 1884, P. Blakiston, Son & Co.: London, J. & A. Churchill.

This is the second volume of the author's "Manual of the Diseases of the Nose and Throat," and is divided into three sections, (I) the Gullet, (II) the Nose, and (III) the Nasopharynx.

The clinician who writes upon diseases of the œsophagus is, of necessity, to a great extent a compiler, and the art of judicious compilation is one of the most difficult and laborious feats of authorship. Dr. Mackenzie has accomplished this task with his usual ability, and has given a condensed, but at the same time thorough, presentation of the subject, which leaves little to be desired as a valuable guide to the study of these imperfectly understood affections. We can testify from personal review of the literature of this subject to the accuracy with which the reference work has been done. We find comparatively few mistakes, and these arise from second-hand quotation, or from the inevitable typographical errors of first editions. The chapters on "cancer", "cicatricial stricture" and "malformations", show signs of careful preparation, and deserve particular commendation.

In Section II, the methods of, and the instruments employed in examination of the nose, are described in two excellent chapters, in which the author contributes a punch and bone forceps, a modified Wildes' snare and a nasal écraseur. We would caution against the use of the latter in the removal of dense turbinated hypertrophies, as it will not stand the necessary strain brought to bear upon it in many operations of this class.

In the chapter on hay fever, the author accepts unconditionally the fallacies of Blackley's work, and we are therefore told the old, old story of how the disease is caused by pollen, and how the individual should not venture out of doors without plugging his nostrils with cotton wool, and having his eyes protected with spectacle frames. In our experience, if there is one condition that contraindicates the use of

powders, it is the irritable state of the nasal mucous membrane in this disease. Yet the author recommends the use of snuffs to be applied by insufflation several times a day. But the briefest mention is made of modern views concerning the etiology of this affection, and what is more remarkable, no mention whatever is made of its treatment by the galvano-cautery.

The important subject of chronic nasal catarrh is despatched in a rather summary manner in one of the shortest chapters of the book. Ulceration is said to be not infrequently met with in simple nasal inflammation, which, if neglected, may lead to perforation of the septum, an accident, which should it occur, must be counted among the curiosities of medicine.

In the chapter on deviation of the septum, no mention is made of the procedure of Bolton, as modified by Steele, although the operation by stellate fracture is given by implication to an English surgeon. The chapters on maggots in the nose is carefully prepared,and is certainly the best in the section.

Section III opens with the consideration of nasopharyngeal catarrh. In some parts of this country there is a widespread popular belief, encouraged to a certain extent by some members of the profession, that dust is the chief factor in the production of nasal disease. As there are some who ascribe all diseases to the peripatetic excursions of a vagrant micrococcus, so there are others who see in dust the source of all our ills. This so-called dust theory is elaborated by the author in the opening chapter. He bases his argument on the assumption that there is more dust in the cities and rural districts of the United States than in those of other countries, and thinks that the disease may therefore be looked upon as a national complaint, for which he offers the name—"American Catarrh." He says: "The universal prevalence of catarrh is, indeed, fully explained by the abundance of dust, both in the country and the cities. Owing to the immense size of the country, and its sparse rural population, the country roads have not, as a rule, been properly made, and except in some of the older States, are merely the original prairie tracks. In the cities, notwithstanding the magnificence of the public buildings, the splendor of many of the private houses, and the beauty of the parks, the pavement is generally worse than it is in the most neglected cities of Europe, such, indeed, as are only to be found in Spain or Turkey. It must be recollected also, that, whilst in the decayed towns of the Old World there is very little movement, in the American cities, there is a ceaseless activity and an abundance of traffic. Hence, the dust is set in motion in the one case, but not in the other. The character of the dust, of course, varies greatly according to locality. In some parts it is a fine sand, in others an alkaline powder, whilst in the cities it is made up of every conceivable abomination, among which, however, decomposing animal and vegetable matters are not the least irritating elements. An idea may, perhaps, be formed of the state of the atmosphere from a consideration of the fact that in many cities the functions of the scavenger are unknown." This, it is needless to observe, is exaggeration, pure and simple.

Apart from the unusual amount of dust in the atmosphere, which results from the geological formation of certain circumscribed sections of our Western States, there is no ground for the statement that there is more of that article in America than elsewhere, (indeed we rather incline to the belief that the reverse may possibly be true) and still less that the region of greatest dust supply is confined between the latitudes of 44 and 38, (see p. 485). Those who have lived amid the "ceaseless activity", or breathed the peculiar soot-laden air of the great Metropolis, and other commercial and manufacturing centres of England, who have experienced the imperfect sanitary conditions of German towns, or have been subjected to the filth and squalor of the "decayed towns of the Old World", will smile at this attempt of our author to base a scientific generalization upon an overdrawn picture.

It is not the purpose of the present review to discuss the etiology of post-nasal catarrh, but we will simply say that our observation lead us to the belief that the great exciting cause of this affection, and that which determines its geographical distribution is that combination of varying metereological conditions which we understand when speaking of a changeable climate; the home of nasal and post-nasal catarrh is the land of the greatest and most rapid thermo and barometrical change.

There are also a vast array of agencies dependent upon modes of life, dress, im-

perfect sanitary conditions, etc., which, although exercising an undoubtedly injurious influence, are, nevertheless, purely secondary and accidental, and cannot therefore be looked upon as essential causes. Very frequently the localization of the disease in the nasopharynx is due to some constitutional affection, as gout, rheumatism, syphilis, etc. We have seen the inflammatory conditions of the nasal pharynx disappear with an attack of acute gout, to make its reappearance when the disease had left the foot. Many chronic post-nasal catarrhs originate during the course of the essential fevers, whooping cough, etc., and so we might go on to enumerate a host of other exciting and predisposing influences. While it is undoubtedly true that dust accidently lodged in the nasopharynx may give rise to inflammation, we nevertheless believe that comparatively few cases originate in that way. In some of the Western States the prevalence of large quantities of dust in the atmosphere is supposed to determine the geographical distribution of the complaint, but even here, in estimating the amount of injury done by dust in this case, we should not forget the important metereological changes that condition its presence in the atmosphere, nor should we lose sight of the fact that these localities are thousands of feet above the water level, a condition that subjects them to sudden variations in the temperature, and brings them directly under the dominion of the winds that sweep across the continent, from sea to sea.

While the equable temperature of England and the comparative freedom from sudden atmospheric changes mitigate the severity of the type encountered there, we are far from believing, as we are led to suppose from the writings of British authors, that the disease is uncommon in that country. During our service in the largest throat clinic of London, we found it much more common than is generally supposed, and we recall many cases marked in the records "laryngitis," which should have had the superscription "post-nasal catarrh."

Dr. Mackenzie next proceeds to strengthen his argument by an attempt to show, that the anatomical relations of the nasal pharynx favor the deposition and retention of dust in that cavity. As the latter is "a *cul-de-sac* out of the direct line of the respiratory tract, particles of foreign matter accidentally lodged in its upper portion are got rid of with difficulty." This sentence contains the partial refutation of the theory it is employed to defend; for the naso-pharynx being situated above the air-passage, it is only accidentally that foreign bodies from the atmosphere become lodged in its interior, the irritative effect of such particles being expended on the inferior nasal meatus, on the lower pharynx and on the laryngeal mucous membrane. This is not only theoretically, but clinically, true. When an individual is exposed to an atmosphere filled with dust, the greater portion of the inhaled particles is retained within the nostrils. This is due, in a great measure, as we have pointed out elsewhere, to the erection of the turbinated corpora cavernosa, which latter serve, in that respect, a certain teleological purpose. That portion which finds its way into the posterior nares is carried into the *lower* (not the upper) pharynx, not only by the force of the inspiratory stream, but also in obedience to the law of gravitation. When the atmosphere is unusually dense, as in storms of dust, this erection of the corpora cavernosa is often so considerable as to necessitate mouth breathing, and it is to a large extent in this way that the lower pharynx and larynx become filled with foreign matter. It is also a notorious fact that the nasal passages themselves, the region of olfaction, is much less liable to catarrhal inflammation than the respiratory passage. The nasal pharynx, therefore, is infinitely less liable to inflammation from a dusty atmosphere than either the larynx or lower pharynx, and we may with more propriety speak of ordinary chronic rhinitis and laryngitis, and, we may add, conjunctivitis, as "American catarrh," than to employ this synonym for inflammation of the retro-nasal space.

Dr. Mackenzie furthermore makes the assertion that reflex acts have no effect upon the upper pharynx, and that the reflex excitability of the latter region is much less acute than that of the nose or larynx. The first is certainly not so in the case of sneezing, and whilst it is undoubtedly true that the voluntary removal of secretion from the nasal-pharynx is more difficult than its discharge from the nose or larynx, we have learned, both from experiment and clinical experience, that the

former region is exquisitely sensitive to reflex-producing impressions.

We can neither confirm nor deny the observation of the author, that post-nasal catarrh is more common in those whose pharynx is large in the antero-posterior diameter, a condition which "facilitates the entrance, without favoring the expulsion of foreign particles;" but we fail to see what appreciable effect such a condition will have upon the *entrance* of foreign bodies into its cavity, as the facility of entrance depends not upon any peculiarity of the receiving cavity, but upon the perviousness of the nostril, its aperture of entrance. As the secretion is removed by a series of voluntary and reflex acts, a slight difference in the antero-posterior diameter of the retro-nasal space will exert an inappreciable influence on its expulsion.

There are a number of other objections which may be brought forward against the dust theory of retro-nasal catarrh, as, for example, the fact that the disease develops and is most severe at those seasons of the year when there is a minimum amount of dust in the atmosphere; but we hardly think the subject worthy of extended serious discussion.

Two well-written chapters on fibrous polypi and malignant growths of the naso-pharynx, and a short account of "throat deafness," terminate the volume.

The work is illustrated with excellent wood cuts, and the general make-up reflects much credit upon both American and English publishers.

On the whole, it represents a great deal of labor and painstaking research. When the erudition of others has been utilized in the preparation of the historical matter, the author has carefully sought out the authorities, and, in some instances, rejected them as unworthy of consideration. Although the reference made has been done to a great extent by assistants, it bears evidence of careful direction and supervision by the author, and it is greatly to his credit that so few mistakes occur.

In the present state of our pathological knowledge, accurate logical definitions of disease is almost impossible, and we question, therefore, the necessity or utility of the author's plan in attempting what, in some instances, amounts simply to imperfect description, and in others to the violation of the criteria of a logical definition.

It is greatly to be regretted that the author has not gone more deeply into the discussion of the questions in nasal pathology that are exciting so much attention at present, and that he has not given us more fully the results of his personal experience in nasal and naso-pharyngeal affections. How invaluable would be the record of upwards of a quarter of a century's observation.

Dr. Mackenzie possesses the rare faculties of perspicuity of style and power of condensation. His accounts of diseases are well written, accurate and trustworthy, and we take the greatest pleasure in recommending this book to the specialist and general practitioner as one of the most interesting and valuable contributions to medical literature of its distinguished author. J. N. M.

BOOKS AND PAMPHLETS RECEIVED.

A Hand-Book of Skin Diseases, and their Homœopathic Treatment. By John R. Kippax, M.D., LL.B., Professor of Principles and Practice of Medicine and Medical Jurisprudence in the Chicago Homœopathic Medical College, etc. Second Edition. Duncan Brothers, Chicago. 1884.

Hand-Book of the Diagnosis and Treatment of Skin Diseases. By Arthur Van Harlingen, M. D., *Professor of Diseases of the Skin in the Philadelphia Polyclinic and College for Graduates in Medicine, etc.* Philadelphia: P. Blackiston, Son & Co. 1884. Pp. 282.

Myths in Medicine and Old-Time Doctors. By Alfred C. Garratt, M.D., Fellow of the Massachusetts Medical Society, etc. New York: G. P. Putman's Sons. 1884.

A Text Book of Practical Medicine. Designed for the use of Students and Practitioners of Medicine. By Alfred L. Loomis, M.D., LL.D. Professor of Pathology and Practical Medicine in the Medical Department of the University of New York, etc. Illustrated. Wm. Wood & Co., New York, 1884. Pp. 1079.

Miscellany.

On the Treatment of Tape-Worm.—In the *Med. Times* of Oct. 11th, 1884, Dr.

Bernard Persh writes of the comparative value of the remedies used for the expulsion of the tape-worm. At a western military post a number of the men were troubled with the parasite, the writer being of the number. Turpentine, ether, pomegranate-root, male fern, kooso, salicylic acid and carbolic acid were tried; and the best results obtained from the use of the last two named. Kooso was given in six drachm doses, suspended in water and followed by one ounce of castor oil. Two grains of carbolic acid were administered in a pill of extract liquorice; if, after a dose of castor oil this treatment failed, it was repeated on the following day. Large doses of carbolic acid may be given without producing disturbance of the digestive organs or carbolic acid poisoning; but in some cases even large doses of the acid failed to expel the worm. Several years after, the writer having been recommended to try croton oil and chloroform as a remedy, did so on himself, and it proved successful where the others had failed. Since that time he has used the treatment on more than twenty cases with excellent result. One drop of croton oil and a drachm of chloroform are suspended in an ounce of glycerine, and administered in the morning before breakfast. The only preparatory treatment consists of a half ounce of Rochelle salt given the preceding evening, which, although not necessary for a cure, facilitates the examination of the evacuations, prevents the breaking of the worm by hard fæces and allows it to pass more quickly through the intestines after becoming detached. The chloroform produces no bad effects; the slight giddiness and drowsiness sometimes noticed was relieved by the recumbent posture and disappeared when the croton oil commenced to operate. The oil acts rapidly, the bowels being moved in about an hour after its administration, and any tendency to diarrhœa or intestinal irritation is readily checked by bismuth and opium after the worm has been expelled. In one case the chloroform alone was efficient in bringing about the expulsion of the worm; but the fact that the worm is always expelled alive, showing that the chloroform, while compelling it to relinquish its hold, is not sufficient to kill it, renders the administration with it of a drastic purgative of rapid action advisable. The author concludes by stating that in the cases treated successfully in this way, other remedies had been unsuccessfully employed. The patients agreed that the remedy was readily taken, that its immediate effects were by no means unpleasant and that the treatment did not leave them prostrated.

Death from the Introduction of a Stomach Tube.—An unmarried woman. æt. 27, with a history of chronic gastritis was being treated by Dr. B., an itinerant doctor, by introducing a stomach tube into the stomach and removing the contents, afterwards washing out the organ. The operation had been twice performed successfully. At the 30th attempt he claimed to have passed the tube into the stomach, when she fell back and immediately expired. I was present at the autopsy. The stomach was dilated considerably and in an advanced stage of chronic inflammation. Numerous spots of ecchymosis were present. The heart was pale and there was fatty infiltration. No other organic changes were noticed. The remainder of the alimentary canal was healthy, as were the liver, spleen and kidneys. She probably died from paralysis of the heart from the shock of the operation. No coroner's inquest was held. This case may serve as a warning to what may happen in any trivial operation upon a patient with a weak, fatty heart.—A. D. Bundy, M. D., *N. Y. Med. Record*, Nov. 1st.

In next week's issue of The Journal will be published a communication from a Fellow of the American Academy of Medicine, answering the letter of "Artium Magister," published in our last issue.

Medical Items.

The newspapers report that Professor Huxley's health is much improved, and that he is about to return from Venice to England.

Dr. Heinrich Neumann, Professor of Psychology at the University of Breslau, one of the leading authorities on mental diseases in Germany, died recently in his 71st year.

According to the *Medical News*, Dr. Paul Grawitz, assistant to Prof. Virchow, has been appointed Professor of Pathological Anatomy in Bellevue Hospital Medical College, New York, and Director of the Carnegie Laboratories. It is said that an understanding has already been had with him, and no doubt is felt as to his acceptance.

Original Articles.

PERFORATION OF THE UTERUS BY THE SOUND, WITH REPORT OF CASES.

BY W. P. CHUNN, M.D.

Assistant to Chair of Gynecology, University of Md. Assistant Surgeon to Woman's Hospital, etc.

Some of the following cases having proved productive of considerable discussion, and having as yet never been published, I desire to put the same upon record in order that those having authority may decide concerning the accuracy of diagnosis as well as the causes of this infrequent accident. By infrequent, I do not mean to say that it does not comparatively often occur, but what I do mean to say is simply this: that very few cases are put upon record. Not long ago a physician of large experience in alluding to this subject, said: "I have many times passed the uterine sound seven and eight inches into the uterus without injury to the patient. *I do not know where it goes, but it never seems to do any harm.*" These were cases where the body of the uterus was not enlarged, as ascertained by bimanual palpation. I think most of such cases would serve as illustrations to the heading of this paper. It has been said by no less an authority than Mr. Lawson Tait, of England, that the passage of the sound through the fundus of the uterus is very common, and is without danger. Such may or may not be the case. In one instance I happen to know of, the patient was made seriously ill, and very nearly lost her life. At all times it should be considered dangerous, and for this reason I trust it may not be considered amiss for me to warn others, more especially as I have myself seen how easily this mishap may occur. From what I have learned, I am inclined to think that this result occurs more feequently with those surgeons who rely too much upon the sound as a means of diagnosis, and that it is most frequent with those who use the sound habitually to correct displacements. The pathological condition of the fundus of the uterus, or of the Fallopian tubes even, which allows a sound to perforate these structures at times without any force being used, I do not as yet feel fully prepared to explain. In two cases, however, I know it was due to abscesses bursting through the uterus and keeping up a fistulous communication. Again, it seemed to me that the tissue of the uterus itself was in fault, and that it must have been made soft and friable by disease, or possibly from lack of proper food to the woman.

The first case of the kind in which I was enabled to make the diagnosis clear, occurred in consultation, and I have made the following notes of it:

Case I.—This woman was about twenty-five years of age, the mother of one child, four years old, and had never had a miscarriage. Her health had been good up to November last (1883), when she came under treatment for the relief of menorrhagia and metrorrhagia. Physical examination discovered the pelvic organs in normal condition, so far as the touch could reveal. Treatment was continued for three months, at the expiration of which time the uterus was curetted. This relieved the trouble for a time, but not entirely. During the month of April I saw the patient in consultation with two other gentlemen, and I proceeded to examine again. Bimanual palpation through lax abdominal walls showed the uterus to be in place, and its position and size were almost normal, the fundus being just on a level with the symphysis. The broad ligaments were elastic, and no enlargement could be felt. The patient was then turned on the left side, in the Sims' position, and the doctor in charge proceeded to introduce the sound, when, to my amazement, he pushed it in ten inches, the handle only preventing the instrument from slipping entirely out of sight. The woman was seized with a sharp pain, and instantly became sick at the stomach. I immediately had her turned on the back, and catching hold of the handle of the sound with my left hand, I proceeded to palpate the abdomen with my right, when at once I discovered the point of the instrument about an inch above the umbilicus, and a little to the right. This could be felt most distinctly through the thin abdominal walls. Both gentlemen present also perceived that it was as I have stated. Here evidently the sound had penetrated the fundus of the uterus, or had pierced the substance of one of the Fallopian tubes in its passage. A flow of blood followed as the instrument was withdrawn. The woman, at my sug-

gestion, was put to bed, and a dose of opium administered to relieve the pain. Strange to say, this woman experienced no inconvenience from this rough usage, as I saw her again, in consultation, two days after with the same gentlemen.

At this second consultation the woman came walking into the room, looking so well that the gentleman in charge of the case took it for granted that the sound had not perforated the uterus at the last meeting, and once more put the patient on the table, and, with the aid of Sims' speculum, proceeded to pass the sound as had been done before. The instrument was again pushed in at least ten inches, and upon the woman being turned upon the back, the point of the sound was again felt in the old position, a little above and to the right of the umbilicus. Much pain was complained of, and a flow of blood took place into the vagina. The patient, however, after a dose of opium and a few days' rest in bed seemed to be no worse for the rough treatment experienced. By some it was said that the sound had slipped into a Fallopian tube, or had possibly slipped out through the fimbriated extremity into the abdominal cavity. Others thought there might have been present a simple dilitation of the tube, or dilitation depending on piosalpinx or salpingitis. To such assumptions I have taken the liberty to differ, and for the following reasons: If piosalpinx had been present, from the lax nature of the abdominal walls, I should have discovered it by bimanual palpation. For the same reason salpingitis is also excluded. From the direction in which the sound was passed, I am certain it could not have followed the direction of the Fallopian tube and in that way have emerged into the abdominal cavity. And, moreover, in the great majority of cases the uterine extremity of the Fallopian tube is of such a small calibre that it is oftentimes almost impossible to pass a straw through them, let alone such an instrument as a Simpson's sound. For these reasons I therefore take it that the sound passed directly through the fundus of the uterus, and thence upward into the abdominal cavity.

The history of Case II was furnished me by a well-known physician of this city; but, owing to an oversight, the notes of this case were not preserved, and although the essential points were remembered, some of the particulars are lacking:

Case II.—This woman was about twenty-five years of age, and was the mother of one child. The last pregnancy occurred some six or eight months before she was examined by the gentleman who related the case to me. She was at times made uncomfortable by various signs and symptoms which point to the disease of the pelvic organs, and it was on account of these infirmities that an examination was made. The usual routine examination was instituted, and it seems nothing of much importance was discovered, except a lacerated cervix. This was, however, considered of sufficient importance to merit an operation. Before operating it was decided that the sound should be introduced in order to gain any other information that might be obtainable. This was done, and it was found that the instrument could be pushed almost wholly out of sight into the cavity of the uterus. There was no particular force used, and the examining physician was a gentleman of large experience. He had no doubt that the sound entered the abdominal cavity, having been pushed through the fundus of the uterus. This patient almost immediately was taken with symptoms of pelvic peritonitis, which in time became fully developed, and, after a tedious illness, she narrowly escaped with her life. I think I may justly refer to this patient as an illustration of the fact that perforation of the uterus is not without danger, in spite of many assertions to the contrary, and the high position of those making such assertions.

The next case to which I wish to invite attention differs somewhat in its pathology from those preceding, but I consider it sufficiently in order to appear under the heading of this paper.

Case III.—This patient was first examined for symptoms of uterine trouble, from which she had suffered some time. As near as could be ascertained, she was about thirty-five years of age, and had never had any children. Nothing of interest was discovered by the usual examination, and the physician in charge proceeded to the use of the sound. This instrument, strange to relate, passed into the interior its whole length, some eight or ten inches, and this without the use of undue force. Upon further investigation it was discovered that a cyst or pelvic abscess had formed an ad-

hesion to the uterus and had then burst into the cavity of the fundus, and in this way kept up a fistulous communication between the two. The history of the case pointed to this fact, and pus could be seen coming through the os uteri. The physician who reported this case to me is known to all of us, and however the result spoken of may be interpreted, I am certain he narrated the truth.

Case IV.—The history of this case is in some respects similar to the one preceding, as will be seen from the following description: The notes of this case were furnished me by the physician in charge, but I unfortunately misplaced them, consequently it is only the main facts that I am able to relate. The patient was much troubled by symptoms of pelvic disease of some kind, and for this reason was examined by her physician, who reported the case to me. The patient was found to be discharging quantities of pus from the bladder, and it was to discover the origin of this discharge that investigation was made. In examination of the uterus by the sound it was discovered that the instrument penetrated seven or eight inches in a uterus which did not seem enlarged by bimanual palpation. The point of the sound was then sought for, and discovered to be in the bladder. In this case a pelvic abscess had formed and burst into the bladder, and at the same time had formed a fistulous communication with the cavity of the uterus through which the sound had passed in its passage.

These two preceding cases both suffered from inflammatory symptoms, and it was only by a careful sifting of the history that the true condition was discovered.

It will be observed that, while in the first two cases related, the sound was pushed directly through the uterine parenchyma, in the second two cases the instrument entered through an opening already in existence. As the results in each class of cases are so likely to be the same, and as the diagnosis, prognosis, and mistakes likely to be arrived at are similar in each, I have classed them together and described them under the same heading.

The next case I have to speak of is as follows:

Case V.—The history of this patient, although brief, is to the point. She was some seventy odd years of age, and for some years back had suffered great inconvenience from an abdominal enlargement. As far as was known she was free from vaginal discharge of any kind, nor was there any disease of the uterus to be discovered. The sound in this case penetrated seven inches, and, as a consequence, the abdominal enlargement was diagnosticated to be a fibrocyst of the uterus.

Fluctuation being very distinct in all directions, and the percussion note being almost universally dull, it was decided necessary to tap in order to relieve the symptoms. This was done, and a small bath-tub full of liquid resulted.

This liquid did not coagulate, was straw-colored, and, in other respects, was typical of ascites. The abdomen was then examined, and as no remaining sac was discovered, the case was diagnosticated as ascites. There was nothing found present to enlarge the uterus. The question then arises, When the sound penetrated seven inches, to where did it go? I answer at once that it penetrated the uterus, and for these reasons, viz.: First. That after the menopause, the uterus always has a tendency to become smaller, and rarely, if ever, exceeds two and a half inches in length. Secondly. The Fallopian tubes are generally almost occluded at their interior extremities, and refuse to permit the passage of the smallest instrument. Thirdly. As nothing was found to enlarge the uterus, it was not enlarged. The inference then seems irresistibly in favor of the diagnosis I have pointed out.

Case VI.—This case first came to my notice while visiting in a neighboring city; and, as it presents some points of interest that all of us may not be familiar with, I will proceed to relate it. A certain woman having become pregnant, in due time fell in labor, and gave birth to a child. Nothing of importance transpired at the time, and the woman was supposed to be doing well. Upon further examination, however, it was perceived that the abdomen had not returned to its proper size, and it was thought at first, a second child was about to be born. This proved the case later on, but the second child, instead of being born *per vies naturales*, was the result of an extrauterine pregnancy, and was delivered by laparotomy. Before operating, it was deemed proper to prove that the uterus was empty, and for that purpose a sound was introduced nine or ten inches into the cavity of the

uterus. The point was distinctly felt through the abdominal walls up underneath the liver. This occurred eighteen days after the first child was expelled from the uterus. With such a history the diagnosis concerning the direction of the sound is not difficult. A uterus measuring eight or ten inches in length, eighteen days after delivery, is, so far as I am aware, without a parallel in the literature on the subject. Subinvolution of such a pronounced type would almost certainly have permitted fatal post-partum hæmorrhage, and that right speedily. And, again, if subinvolution had been present, by which the sound might have entered ten inches without perforation, the walls of such a uterus must necessarily have been so thick that the point of the sound could not be felt at all. It may be stated, as a general rule in gynecology that the length of the uterus is in proportion to the thickness of its walls. Having given these reasons for my belief and diagnosis in Case VI, I now pass on to

Case VII.—The history of this case is given in full in the *American Journal of Obstetrics for May*, 1884, *page* 525.

"Persistent Flaccidity of the Uterus After Delivery."—The case was recited by Dr. Perry, and under his treatment a cure resulted. The history of this case, as Dr. P. relates it, is as follows:

The patient was thirty-eight years of age, the mother of five children, the youngest being four years old. Since the last child, she had been troubled with weight and pain in the pelvis. Upon a vaginal examination the cervix was found in place, but was soft and flaccid, and extended around in a circular direction, a soft mass, apparrently the result of a pelvic inflammation. On conjoined manipulation, nowhere could the fundus of the uterus be discovered. A sound was introduced, which penetrated two inches. Not doubting it was in the uterine canal, he essayed a little force, and with this was able to penetrate to the depth of eight inches, and while doing so, found that the mass in the pelvis disappeared. He had, indeed, while forcing the sound upwards carried the uterine wall before it. Dr. Perry thought this a case of subinvolution, resulting from sudden and complete cessation of contraction after labor. Some, he thought, might regard it as a case of paralysis. I am obliged to confess that I differ with Dr. Perry, and that I think the sound perforated the parenchyma of the uterus. I sincerely trust, however, that no one will think that I differ in opinion for the mere sake of criticism, for such is not the case. It is only the truth that I desire, and when that is demonstrated, if I am found to be in error, none could be more glad to acknowledge it than myself.

Let us now see what reasons may be advanced in support of my opinion. Here was a uterus, according to the history, with the fundus low down in the pelvis having occupied that position some four years. To raise such a uterus perpendicularly eight inches in the pelvis on the point of the sound, consider for one moment what a resistance would have to be overcome. There are the tense broad ligaments on each side to keep it in place. Behind we have the utero-sacral ligaments; in front the round ligaments, and the vesico-uterine ligaments below the vagina. Pressing down from above was the superincumbent weight of the intestines. After all these structures had been in position four years, is it reasonable to suppose they would in a moment stretch eight inches in length, the whole weight of the pelvic viscera, also being an obstacle to the ascent of the uterus? And, again, according to the history of the case, we have a subinvoluted uterus eight inches in length, which could not be felt by conjoined manipulation. So far as I know, if such was the fact, it stands alone, a condition unique in the history of gynecology.

Dr. Thomas, in his systematic book on Diseases of Women, mentions no such case. Barnes, in his work, does not allude to such a condition. Hewitt's Diseases of Women, edited by H. Marion Sims, speaks of no similar case. Other gentlemen of experience have said that they were unfamiliar with such a condition. In my own experience, which has been limited to the examination of some 5,000 women, it is useless for me to state that I have never seen a similar case. But what is unexplainable by the theory given may very readily be explained by another—the one I have already presented. And, again, it was stated that while the sound was being forced upward the mass in the pelvis disappeared. I would ask how the operator was aware of the fact that the mass alluded to disappeared. Was his finger in the vagina while he was using the sound? If the mass disappeared, to where did it disappear? Was it

impossible to feel the point of the sound through the abdominal walls when it was said to extend up eight inches above the os externum? All these questions remain at present unanswered. According to the best authors on the subject, a uterus remaining subinvoluted after delivery either becomes prolapsed, anteverted, retroverted, or laterally inclined, but no where do I find an account of a uterus spread out around the cervix as a mushroom spreads out around its stalk. It must also be borne in mind that force was used in handling the sound. I have seen penetration of the fundus occur without any force being used whatever.

In the discussion that followed upon Dr. Perry's case, Dr. Robert Watts said that two similar cases had been related to the Society, and in one of them he had passed the sound nine inches up into the uterine cavity, and it could be felt through the abdominal walls. In the other case the sound passed eight and a half inches.

These two cases having, like those preceding, similar histories, with similar treatment, of course admit of a similar diagnosis. By way of explanation, Dr. Watts said that Dr. Isaac E. Taylor called the case one of "balloon uterus." This discussion is reported in the May number of the above-named Journal. In the June number of the same Journal, Dr. Isaac E. Taylor replies to Dr. Watts by saying that "it was the first time that such cases had been accredited to him as balloon uteri, and that he should have supposed they never could have been entitled to such a name." It will be seen that I have mentioned nine cases. In some of them I regard the diagnosis as proven. In others the diagnosis seems as certain as anything not absolutely proven can be. As the length of the uterine cavity is oftentimes of great importance in enabling one to arrive at an accurate diagnosis, I have in this paper endeavored to bring more fully into view certain errors which may occur during the use of the sound. By being always on our guard, we may make allowance for such errors, and in the end be enabled to distinguish that which is true from that which is false.

Dr. William P. Bird, of South River, Anne Arundel County, Md., died Oct. 15th, aged 60 odd, of typhoid fever.

SPECIMEN OF PERFORATING ABSCESS OF LIVER WITH REMARKS ON SAME.

BY W. PAGE MCINTOSH, M.D., OF BALTIMORE,

Resident Physician, Bay View Asylum.

Although abscesses of the liver in our climate do not belong to the great pathological varieties, the present case seems to present sufficient points of interest to warrant me in reporting it.

Amos Stewart, colored, male, æt. 42 years, admitted to colored male hospital of Bay View Asylum, September 5, 1884. At time of admission the man was very much emaciated, with a great deal of cough and expectoration, considerable fever and persistent diarrhœa. An examination showed the presence of a large cavity in lower portion of right lung, surrounded by an area of consolidated lung tissue. A diagnosis of chronic tuberculosis was made.

All of the symptoms increased in severity; on September 9th and 12th there were slight hæmorrhages from the lungs. Patient died September 19th, two weeks after admission.

Nothing known of history previous to admission to hospital.

Post-mortem eight hours after death. *Description:* The body large, slightly built, very much emaciated, anæmic. Examination of brain and cord revealed no abnormalities, heart of ordinary size, its valves soft. Left lung slightly adherent to pleura, its tissue pale. The upper lobe of of right lung adherent to pleura by some old and tough adhesions. The entire lower lobe of right lung intimately adherent to the pleura and to the diaphragm. An attempt was made to remove it by stripping off the parietal pleura with the lung, when it was found that the entire lobe was occupied by a cavity from which on pressure, pus freely welled up through the large bronchus leading into the lobe. The lungs were removed with the diaphragm and the liver; an examination now showed the presence of an abscess in the liver the size of a small orange, seated immediately beneath the diaphragm. The liver was intimately adherent to the diaphragm at this point by adhesions which were easily broken away. Immediately above the abscess in the liver there was an opening in the diaphragm as

large as a half-dollar, which led directly into the cavity in the lower lobe of right lung. This cavity was filled with a stinking pus, which contained floating in it shreads of necrotic lung tissue. There was no well-defined wall to the abscess cavity in the lung, but masses of lung tissue which had undergone necrosis, and apparently represented only the elastic tissue of lung, projecting into the cavity. The lung tissue around the abscess was of a greyish color, firm and hepatized; a large bronchus led directly into the cavity. The spleen was slightly enlarged, its capsule thickened. Both kidneys large and pale. The colon was ulcerated in some places, and only shreads of the mucous membrane could be found between the ulcerations At other places the surface of the gut was covered with an exudation, in part croupous and in part diphtheritic; the most marked changes were found in the ascending colon. The mucous membrane of small intestine somewhat thickened and hyperæmic in the lower portion of ilium, elsewhere normal. The mesenteric glands were all swollen and hyperæmic.

This termination of abscess of the liver is rather an unusual one, but cases are not uncommon where perforation took place into the pleura alone from liver abscess.

It seems most probable that before perforation into the lung itself could take place that the lung would have to be previously bound to diaphragm by old pleuritic adhesions; an adhesive pleuritis might precede the opening of the abscess into the pleura, thus binding the lung at this point, just as an adhesive peritonitis had bound the liver to the diaphragm in the case exhibited. We have abundant evidence from the presence of strong adhesions between visceral and parietal pleura over entire lower lobe of of lung and slight adhesions in other parts of lung, that previous adhesions existed between the lung and diaphragm.

Among the causes of abscess of the liver we find,

First:—Contusion of the organ. In sixty-two cases, Budd found two due to this cause. Moorehead had four out of three hundred and eighteen cases.

Second:—Pyæmic inflammation of liver. This question has been fully discussed by the authorities.

Third:—Operations about the anus and injuries to vena porta are recognized causes, as is inflammation of veins of the systemic circulation. It is still, however, a mooted question as to how emboli get into the vessels leading to the liver, from this source, having to traverse the capillary system of the lungs before reaching that of the liver. The fact that thrombi are found in the hepatic vein, and not in the hepatic artery or portal vein, seems to lend something of an air of probability to the theory advanced by Magendie, Meckel and others that they reach this point from a backward flow from vena cava "F." It is shown by Freirichs, however, that quicksilver injected into the jugular veins shows itself in the hepatic vein as also in the veins of the lungs, causing abscess in the latter, but not in the former. On the contrary, Cruvelheir found that quicksilver injected into the mesenteric or other branches leading to portal was quickly followed by the appearance of pus areas in liver. From this we would infer that though thrombi are found in the hepatic vein, they are not competent to cause abscess of liver.

Inflammation and ulceration in gastro-intestinal canal does occur, as we know, and is a frequent cause of jaundice, but then it can hardly be regarded as a cause of abscess, else acute hepatitis would be infinitely more common than it is.

Dysentery being frequently present in abscess of liver, Ribes advanced the theory, afterwards accepted by Budd, that the infective material was conveyed from the diseased gut to the liver by the portal vein. If this was the case, abscess should occur under the favorable conditions afforded by abdominal typhus and tubercular ulceration.

The hepatitis precedes the dysentery quite as often as is the reverse. Warring found, out of 300 cases of hepatic abscess proving fatal in West Indies, only 82, or, 27.3 per cent. were preceded by this trouble. When, as out of 203 cases noted, 51, or exactly one-fourth had ulcerations, abrasions or cicatrices in large gut.

Ulcerations of gall-ducts from impacted concretions or intestinal worms occasionally give rise to hepatic abscess. Many cases arise without appreciable cause. This is not strange, however, since we know quite as little about inflammation of the liver as we do about inflammation of the lung.

In the case under discussion, the most probable hypothesis is that we have to do with a case of direct infection of the liver

by means of emboli of a highly irritating and inflammatory nature carried through the mesenteric vessels of the colon. These emboli are most probably micrococci. Such emboli of micrococci have been reported by various observers, in liver abscess supervening upon malignant dysenteria. An examination of the pus from this case showed the presence of innumerable lower organisms; though this could be readily explained from the connection of the abscess in the lung with the open bronchi.

We have to differentiate:

First:—From serous cysts and echinococci. Their slow growth, absence of pain and febrile symptoms, with but little impairment of nutrition, tell us the difference.

Second:—From inflammation and distension of gall-bladder; by the position and shape of tumor, absence of hectic fever and generally of jaundice.

Third:—From cancer; by its history, presence of hard nodular masses, absence of fluctuation and fever.

Fourth:—The diagnosis of such an abscess in the lung and a tubercular cavity is somewhat more difficult. In this case, from the emaciation of the man; from the constant cough and expectoration of seropurulent matter; from physical signs of large cavity in lung, with consolidation of lung tissue in neighborhood, the diagnosis of tuberculosis was made. The profuse diarrhœa was supposed to be due to tubercular ulcers in the ilium, the consolidation of the lung around the abscess was due to the advance of the inflammatory process, and to the small cell infiltration which had not yet broken down into the abscess cavity. In this, as in many other cases, after death takes place and we have the pathological process under our hands and eyes, it is easy to see why the diagnosis should have been different. It is doubtful whether, in the absence of tuberculosis elsewhere, there could be a tubercular cavity, the size stated, seated in this portion of the lung. Almost necessarily, even had a tubercular process started in this portion of the lung, other portions would have been effected. An important point in establishing the diagnosis between an abscess of this kind and tubercular cavity would be the presence of disintegrated hepatic tissue or bile in the sputa.

The diagnosis could have been made absolutely certain by an examination made with regard to the presence of tubercular bacilli. Unfortunately no such examination was made. While in this case the presence of tubercular bacilli would have settled the point, cases might occur when liver abscess and tuberculosis were present in the same individual.

CLINICAL EXPERIENCE WITH THE NEW LOCAL ANÆSTHETIC—MURIATE OF COCAINE.

BY SAMUEL THEOBALD, M.D.,

Professor of Diseases of the Eye and Ear in the Baltimore Polyclinic and Post-Graduate Medical School; Surgeon to the Baltimore Eye, Ear and Throat Charity Hospital.

Within the past two weeks I have had the opportunity of testing, in a variety of cases, the action of the new local anæsthetic, the muriate of cocaine, which was recently brought to the attention of the medical profession in this country by Dr. Noyes' letter to the *Medical Record;* and, although the published experience of those who had experimented with it led me to expect marvellous things of it, my expectations have been fully realized. So far, I have made use only of a two per cent. solution, and of this I have usually put into the eye (for my employment of it has been confined to ophthalmic surgery) two drops at intervals of five minutes, making three applications in all, and beginning the operation at the expiration of fifteen minutes from the first instillation.

The first case in which I tried it was one in which a foreign body was adherent to the cornea. Three applications were made in the manner described, and fifteen minutes after the first one the pupil was found to be semi-dilated, and the cornea completely anæsthetic. The foreign body was removed without the patient feeling the slightest discomfort. Since then I have used it in two other cases of similar character, and in each the same perfect anæsthesia was obtained. In one of these the foreign body had been in the cornea for several days, and the eye was considerably inflamed and very irritable; but, although the needle was quite freely used to detach the somewhat deeply imbedded particle of iron, the

patient showed by his behavior, and declared likewise, that the operation was entirely painless.

Having occasion to remove a pterygium from the eye of a very nervous, timid woman a few days since, I made the usual three applications of the cocaine, and was then able to perform the operation with perfect ease, the patient assuring me that she felt no pain whatever.

Among the first cases in which I employed it was one of acute inflammatory glaucoma, upon which it was necessary to perform an iridectomy. In this case four instillations were made; but, owing to the cloudiness of the cornea, the chemotic condition of the conjunctiva and the high tension of the eye, the drug was, probably, very imperfectly absorbed (the pupil showed no mydriasis), and the anæsthesia obtained was not complete. Still the operation was finished without difficulty, and the patient asserted that it caused very much less pain than she had suffered from an iridectomy previously performed upon the other eye without anæsthesia.

The division of a dense capsular opacity, by means of a needle-knife introduced through the cornea, was done under its influence with much satisfaction, though the manipulation of the needle was not entirely unattended by pain.

A canaliculus was slit up in a very nervous woman after three applications of the cocaine, and the pain attending it was certainly much less than usual.

Several concretions of cheesy matter were scraped from the cornea of a young girl after the usual three instillations of the solution. Both eyes were completely devoid of feeling, and the operation caused no pain whatever.

A man with badly lacerated lids required not only to have four stitches introduced, but also to have the edges of the torn tissue which were to be brought in apposition freshened with the knife, as the injury had occurred some days previously. Here the solution was not only dropped into the eye, but applied by means of absorbent cotton to the lids. The operation upon the lower lid, to which the cocaine was doubtless more thoroughly applied, was evidently attended by but little pain, although the introduction of two sutures was required; but that upon the upper lid caused decidedly more suffering.

Two days since I enucleated an eye under its influence, and obtained an astonishing effect from it, though I did not promise or expect complete anæsthesia. The introduction of the speculum, the seizing of the conjunctiva with the forceps and its dissection from around the cornea seemed to cause the patient (a man about forty years of age) *no pain;* but the section of the external muscles and the division of the nerves back of the eye were evidently attended by severe pain, although the cocaine solution was several times dropped into the eye during the performance of the operation, and was gotten, to some extent, under the conjunctiva. Whether under such circumstances a stronger solution would produce a more satisfactory degree of anæsthesia is a question which, doubtless, will soon be determined. Probably it will not be practicable to obviate entirely the pain attending section of the ciliary nerves behind the ball; but by waiting for the bleeding to cease after dissecting up the conjunctiva, injecting the cocaine into the sub-conjunctival tissues; and waiting again a sufficient time for it to produce its anæsthetic influence there, it will doubtless be possible to cut through the muscular attachments of the eye without pain, and to complete the enucleation with but a trifling amount of suffering.

That in the treatment of inflammations of the eye, more especially of corneal affections, the cocaine will prove a most valuable agent, seems altogether probable, in view of the marked influence which it has been found to exert in controlling photophobia and ciliary irritation. I have already employed it in a case of extreme photophobia, blepharo-spasm and lachrymation—attending a relapse of granular conjunctivitis—with apparently marked benefit, the symptoms of ciliary irritation having almost entirely disappeared after ten days' use of the drug, a two per cent. solution having been applied to the eye four times a day. It should be stated, however, that in addition to the cocaine instillations, a daily application of sulphate of copper was made.

Whatever cocaine may accomplish in other departments of surgery, the discovery of its anæsthetic influence upon the eye marks an era in the development of ophthalmology. It is an event, the importance of which we can, as yet, scarcely appreciate.

MURIATE OF COCAINE IN VENEREAL SURGERY.

BY J. EDWIN MICHAEL, A.M., M.D.,
Professor of Anatomy and Clinical Surgery in the University of Maryland, Professor of Genito-Urinary Surgery in the Baltimore Poly-Clinic, Surgeon to the University Hospital and Bay View Asylum, etc.

When the muriate of cocaine was under discussion at a recent meeting of the Baltimore Academy of Medicine, I expressed the hope and belief that the drug would probably find a large field of usefulness in genito-urinary surgery. In fact, the experiments performed by Dr. Knapp on himself left little room for doubt in regard to the matter. A drug which exercises so marvellous an influence on the eye must also be potent elsewhere, at least the presumption is strong enough to warrant a clinical trial. The result in the five cases recorded below is, I think, sufficiently interesting to warrant publication.

Case I.—J. B., aged 21, colored. The patient has suffered for several months with venereal sores which have left his penis in a condition not strictly classical. There have been several losses of substance both in glans and prepuce. In the left rectro-glandular sulcus have developed a number of ordinary venereal warts with rather broad bases, and giving rise to the usual symptoms. The patient was directed to hold the head of his penis up, retracting the prepuce so as to expose the warts, and a few drops of the 4 p. c. solution of the muriate of cocaine dropped upon them. This was repeated at intervals of five minutes, until three applications had been made. The warts were then snipped off with scissors, and the bases treated with Monsel's solution. The operation cannot be said to have been painless, but there was evidently *very much less pain* than is usual under such treatment.

Case II.—W. D., aged 20, colored. The patient has acquired phimosis, and a rather redundant prepuce. He was directed to hold his penis up, and a few drops of the 4 p. c. solution were injected under his prepuce. A strip of absorbent cotton soaked in the same solution was also wrapped around the outside about where the incision was to be made. A few drops were injected, and the cotton remoistened every five minutes until three applications had been made. The sutures were then introduced, and the prepuce removed, the patient showing very slight evidences of pain during the operation. In fact he was chatting with some of the students during its progress. The last step of the operation was the introduction of a suture near the frænum. It was noticed that the passage of the needle through the mucous membrane gave rise to no pain at all, while its passage through the skin was quite perceptible, though only slightly painful.

Case III.—C. K., aged 28, German. Contracted meatus with chronic gonorrhœa. A pledget of absorbent cotton wrapped on a probe was soaked in the solution, and placed in the meatus. It was remoistened every five minutes as in the other cases. When the patient was placed on the table, the neighborhood of the meatus was distinctly blanched. The incision was felt, but gave rise to no pain.

Case IV.—R. T., aged 33, German. Suppurating bubo in the left groin. This patient was very sensitive, and very much frightened. The surface of the bubo (to which a poultice had been applied for several days,) was treated in the same manner as in the previous cases. When the pledget of cotton was removed from it, it was distinctly blanched. The patient was talking when I introduced the bistouri, and it did not interrupt his conversation. He felt the last part of the incision (which was about an inch long), but said it did not hurt him.

Case V.—W. A., aged 17, colored. Three small ulcers on the upper surface of the glans, one below near frænum. The three upper sores were treated as described above with the cocaine solution. At the end of a quarter of an hour a saturated solution of zinc chloride was thoroughly applied to the upper three. I asked the patient if it hurt, and he replied, unhesitatingly, "no." The penis was then turned up, and the lower sore touched, whereupon the patient gave the usual evidences of the activity of the caustic.

These experiments were done at Bayview Hospital, in the presence of the Medical Class of the University of Maryland, and their success was enthusiastically appreciated. I propose to continue them, as opportunity offers. They seem to show that the local anæsthetic powers of cocaine may be made use of wherever we need surface anæsthesia and have an absorbent surface.

Hospital Reports.

THE MURIATE OF COCAINE:

Its use at the Presbyterian Eye, Ear and Throat Charity Hospital of Baltimore.

This new, wonderful and innocent local anæsthetic is domiciled among us, and has evidently come to stay. No drug introduced to physicians in the past century has been so promptly adopted, so extensively tested, and so generally endorsed. As a substitute for dangerous, general anæsthetics, its advent is hailed with rejoicing, which seem to have extended with electric speed to all civilized countries. It is only one month since its existence was heralded to our shores,and yet there is scarcely a physician among the 70,000 who practice in our extensive domains who have not heard of its miraculous work, and many of whom have tested for themselves its wonderful controlling power over the common sensation of mucous surfaces. The loud praises of the eye specialists have induced other specialists to test its virtues on other parts than the eye. In the ear, nose and mouth, vagina, urethra, rectum; on ulcers, on any broken cutaneous surface, or otherwise on the skin or under the skin; wherever any pain is being experienced, or it is desirable to prevent it, this magic drug has not failed the physician in doing its honest work. Its scope seems to be as wide as surgery itself, and its blessings to suffering humanity incalculable.

Among our surgeons, Dr. Julian J. Chisolm was the first who succeeded in getting a supply of the precious drug, and guided by what the pioneers had done, went boldly to work with it. At the Presbyterian Eye, Ear and Throat Charity Hospital he had an abundance of material upon which the efficacy of cocaine could be tested. He first tried it for allaying the intense pain and photophobia of corneal ulcers.

Its action was prompt. Positive relief to the severe suffering came in a few minutes, so that the patient could expose the eye for inspection to sun-light. To this class of patients, the immense army of children suffering throughout the world with phlyctenular ophthalmia, cocaine will be a haven of rest. Put into the inflamed eye four or five times a day, it stops pain, keeps the eye quiet, removes pain upon the exposure to light, permits the child to leave the dark corner of the room, or does away with the desire to hide the face in a pillow or the mother's lap. It seems to shrink the blood vessels, diminishes the ocular congestion, and starts the little sufferer on the road to convalescence, For the ophthalmia of children alone, if it had no other soothing power, the drug would be invaluable.

Another case was the removal of a foreign body from the cornea. When a particle of cinder or dust gets by accident into the eye, each one of us knows the suffering it occasions, and how difficult it is to keep quiet long enough to have the foreign body removed. Should it be a sharp particle of metal, or a hot iron scale, a piece of emery, which will imbed itself in the surface of the cornea, the disposition to hide the cornea under the upper lid becomes irresistible, and the difficulty of removal is immensely increased. The trouble in this class of cases is now gone. A few drops of cocaine with a few minutes of patience, and all sensation leaves the cornea, so that the foreign body can be picked off from the eye with as little discomfort as if from a button upon the patient's coat. The change induced in a most sensitive eye in a few minutes must be seen to be appreciated. It is truly wonderful. Every day mechanics apply at the Eye Hospital to have such fragments removed, and heretofore some general anæsthetic has been at times required, either chloroform, ether or ethyl, to enable the surgeon to remove the foreign body without doing violence to the eye. Cocaine is truly a blessing to this large class of suffering workmen.

The next case tried was in a squinting child, who desired to have the eyes made straight. Several hundred of these cases have been operated upon at the hospital, formerly under chloroform, and more recently under the bromide of ethyl. In the first strabismic case, a drop of the muriate of cocaine, 2 per cent. solution, repeated every three minutes for a quarter of an hour, allowed the conjunctiva to be pinched and rudely handled without apparently causing any suffering. With this evidence that the operation of crossed eyes could be performed without discomfort to the patient it was undertaken. In the section of the conjunctiva there was no change of

facial expression. Even when the tendon was caught up on the hook and dissected off from the sclerotic there was no pain induced, and the tenotomy was speedily and successfully completed without suffering. During the past three weeks Dr. Chisolm has repeated this operation for crossed eyes on ten children, and with most successful results. One little timid girl of nine yeais of age, when assured that the operation would not hurt her, and that she must not throw up her hands to annoy the operator, folded her hands behind her back, laying upon them, till the operation for squint had been completed, and then expressed herself as not having felt any pain beyond the pulling of the eye, which did not hurt her. There is no dissembling in children. Give them an occasion to cry for pain, real or imaginary, and they usually take advantage of it. Some of the best tests of the anæsthetic effects of cocaine are obtained from this class of patients. For squint operations cocaine will become the universal local anæsthetic, and will at once rob such operations of all terror, shared heretofore by both child and parent.

The next patient operated upon was one of tear drop with a mucocele in each eye. In her, the experiment was tried of influencing one eye alone, so that by contrast the efficacy of the anæsthetic could be experienced. She was a stolid german, and did not give any evidence of suffering when either canal was split. She, however, said that the eye in which the drops were placed did not hurt her, and that there was some pain in the section of the second eye. Dr. Chisolm has repeated this operation, and finds that unless the cocaine solution can traverse the lachrymal canals and enter the sac, the pain of opening the tear tubes is not altogether prevented, although it is much mitigated by the application of the cocaine drops.

The crowning work for cocaine in eye surgery is in the extraction of cataract, the most delicate operation of the eye surgeon. For the testing of the anæsthetic effect in this operation the Presbyterian Eye, Ear and Throat Charity Hospital offered every facility. On one day 5 cataracts were extracted, and four days afterwards 6 other cases of senile cataract were admitted and operated upon by Dr. Chisolm, making 11 cases within the week. It was in this class of cases that the miraculous eye drop put in its most telling work. A number of the leading medical gentlemen of Baltimore were present to see the working of the new anæsthetic. The results to these observations were that eye surgery was now perfect. In all of these cases the 2 p. c. solution of the muriate of cocaine was instilled into the eye every 3 minutes, for from 15 to 20 minutes. As soon as the pupil was fully dilated the anæsthetic action was established, and the eye ready for operation. Having been previously prepared by the instillation of this eye-drop in the wards these patients were brought out one after another, and put upon the operating table. As soon as the conjunctiva was seized with the forceps and no pain evidenced, the patients gave themselves up to the surgeon, with face settled down with the conviction that they were not to feel any pain; nor did they. In not one did the section of the cornea seem to produce any uneasiness whatever. In the iridectomy some experienced pain, many made no movement of the eye, nor did they change the facial expression. The capsulotomy and the squeezing out of the lens was a painless proceeding. One female patient, when asked if the cutting was painful said, "I heard you cut me, but did not feel it." When asked for an explanation of what she meant, she said, "The cutting of the eye sounded to her like the noise made in cutting stiff muslin." Dr. Chisolm has in the past two weeks tested the value of cocaine as a local anæsthetic in 15 cases of senile cataract, and in every instance so perfectly has the new anæsthetic worked that he has gone back on his old favorites. One month since these 15 patients would bave been cases for chloroform anæsthesia. Now he finds his chloroform bottle remaining corked. Even the bromide of ethyl, which he used so skilfully before the Medical Classes of the University of Md., for the past two years, has been put away for the new friend, cocaine, which seems to have completely overshadowed its former powerful but dangerous competitors. The greatest dread of patients who had to undergo cataract extractions, heretofore, was from the inhalation of chloroform or ether. Under the new order of things, with eye alone under the subjection of the cocaine, and the rest of the body undisturbed, the patient talks with the operator, while the section is going on, and with the undisturbed air of a

looker-on in Venice. He has no pain, therefore feels no anxiety. The cure in all of the cases operated upon seems to progress most favorably. The oldest cataract case was operated upon 18 days' since. She had no pain from the day of operation to the present, when she is enjoying excellent sight. All of those operated upon for cataract extraction are enjoying a similar comfortable convalescence. The absence of nausea or vomiting in a Hospital ward, with beds filled with eye patients, just from the operating room, is a comfort that only the surgeon and the nurses can fully appreciate.

In iridectomies, whether for glaucoma or for artificial pupil, cocaine acts with its uniformly good controlling power.

Although the muriate of cocaine is worth 60 cents a grain, two grains in one hundred drops of water makes the 2 p. c. solution, 5 or 6 drops of this solution prepares the eye for operation. From the standpoint of economy it is cheaper than chloroform, ether or ethyl.

To physicians desirous of seeing the wonderful medical discovery of the 19th century, we would suggest a visit to the Presbyterian Eye, Ear and Throat Charity Hospital. The cocaine local anæsthetic is used daily by Dr. Chisolm, and the Clinic at the Hospital is so very large that patients are applying there every day for operations.

Society Reports.

PHILADELPHIA OBSTETRICAL SOCIETY.

STATED MEETING, HELD NOVEMBER 6, 1884.

The President, R. A. CLEEMANN, M.D., in the Chair.

REMOVAL OF UTERINE APPENDAGES FOR MENSTRUAL EPILEPSY—RECOVERY.—*Dr. E. E. Montgomery* exhibited the specimens and read the history of the case. Sarah H, æt. 17 years, was admitted to the Philadelphia Hospital, April 1, 1884. She suffered from an attack of inflammatory rheumatism in childhood, and began to have epileptic seizures in her thirteenth year. These were slight at first, but have recurred every month, increasing in number and violence, so that at present she is unconscious from ten days to two weeks out of each month. There has only once been a trace of menstrual discharge, and that for a single day only. There is no history of any chronic disease in the family; brothers and sisters are healthy. The patient was pale, flabby, anæmic, poorly developed and extremely nervous. The external genitals were but slightly developed, the uterus small, and no special tenderness over the pelvis. Iron, tonics and a generous diet were given; the bromides were not well borne. Owing to her youth, and the fact that she had not yet menstruated, it was deemed best to undertake to establish the menstrual function and exhaust the antispasmodics before resorting to operative interference. The failure of all remedial measures was complete, and on September 13th the operation was performed; both ovaries and tubes were removed. No antiseptic was used about the wound; all the water used had been well boiled; absorbent cotton was placed over the wound, which had been closed with silk sutures. The operation occupied thirty-five minutes. The recovery was uninterrupted until the night of the 26th of September, when she had four epileptic seizures. There were recurrences of slighter attacks during the next three nights, but they were shorter, and during the intervals she was perfectly conscious. During the first four days of October spells of staring with momentary unconsciousness occurred becoming less frequent and lighter. A well marked convulsion on the night of October 14th was followed by from one to four convulsions daily, until the 29th. But they have not been so severe as before the operation.

REMOVAL OF PAROVARIAN CYST—RECOVERY.—*Dr. E. E. Montgomery* presented the specimens, and related the history as follows: Mrs. A., æt. 30 years, native of England, married, never pregnant, has suffered from an enlargement of the abdomen for seven years. As it was first noticed a few months after her marriage she supposed herself pregnant. Her menses have never been interrupted; now occur every three weeks; are very slight, and have never been excessive. She suffers from severe pain the week before menstruation over the lower portion of the abdomen, and through the hips. She suffers at other times from pain in the feet and legs, and from a sensation of weight. The tumor has been tapped some six times; the fluid was

always of a pale straw color. The largest quantity removed, at any one time, was 40 lbs. Previous to its removal her weight was 102 lbs. The last tapping was on June 27th, 1884. She has had four attacks of peritonitis.

When first seen last July, two weeks after the last tapping, the abdomen was swollen and tender to pressure; fluctuation was distinct. Since that time the abdomen has increased considerably in size, presenting a prominent tumor distending the whole abdomen, nearly symmetrical, but projecting slightly to the right side; circumference at umbilicus 32″, distance from symphisis to umbillicus 7″, to ensiform 13″; fluctuation distinct over the whole tumor, coughing projects the whole mass forward and downward. Her general condition is good, she is quite active. *Diagnosis*: A Parovarian Cyst. *Plan of Operation*: Exploratory incision, remove the tumor if possible, but if the adhesions were too great to permit that, then to open the sac, stitch it to the integument, and introduce a drainage tube and thus secure obliteration of the sac.

Operation, Oct. 9th, abdominal wound 4″, adhesions universal, but generally broken up without difficulty, no ligatures were needed. The intestines were not seen, being concealed by old inflammatory deposits. The right ovary was enlarged and was also removed. The wound was closed with seven sutures and a glass drainage tube introduced. Salicylated cotton in a thick layer was placed over the wound. Suppositories of morphia were used to control pain which continued to a greater or less extent for two weeks, arising partly from inflammatory conditions and partly from collections of gas in the intestines. The abdominal wound discharged freely three ounces the first day. The drainage tube was removed on the 13th, four days after the operation, but the discharge of bloody serum, pus and flaky lymph continued for full two weeks later, when the wound closed entirely and the patient was discharged.

Dr. B. F. Baer presented the specimens and read the following report of a case of PLACENTAL POLYPUS WHICH SIMULATED MALIGNANT DISEASE OF THE UTERUS. The patient was thirty-five years of age, married and had two children at full term, the last twelve years ago. She has had several abortions since, but otherwise she has enjoyed good health. Her mother died at the age of thirty-eight of cancer of the uterus. In the early months of this year our patient first noticed that her catameniæ were becoming too frequent, and were attended with expulsive pains, and a fetid watery discharge in the intervals. The blood loss increased in quantity, and she soon began to show signs of failing health in pallor and loss of flesh. She would not permit a physical exploration until the latter part of July, when she had a violent flooding with great pain. *Examination* now revealed to Dr. R. Armstrong, of Lockhaven, Pa., whose patient she was, a healthy condition of the cervix and a normal os, but the body of the uterus was enlarged to more than double its natural dimensions, it seemed to be symmetrical and rather softer than usual. The hemorrhage was controlled by ergot and rest. Although the grumous, fetid discharge and the uterine tenesmus continued, she did not have another severe attack of metrorrhagia, probably because of her exsanguine condition, and the fact that she was suffering from septic absorption. Her temperature rising as high as 104° in the afternoon, she had distinct rigors. Her abdomen was tympanitic and very tender to the touch. The physical condition of the uterus led the Doctor to introduce two tents into the cervical canal on September 23rd. They were allowed to remain 24 hours, although their presence increased the violence of the symptoms. When the tents were removed a rather soft, friable mass could be felt presenting at the internal os. This led to a fear that the disease might prove to be malignant. A severe colliquative diarrhœa now set in and the patient's strength became so much reduced that nothing could be done except to administer remedies to check the diarrhœa and prevent collapse. On the morning of the 25th, through the kindness of Dr. Armstrong, I saw the patient, temperature 103°, pulse rapid and weak, stomach irritable, rejecting everything taken, bowels still quite relaxed. Her face presented the ashy hue of malignant disease. The outlook was not favorable for an operation which would necessitate the dilatation of the cervix sufficiently to remove the diseased tissue which evidently occupied the uterine cavity, but it was the only course to pursue. Ether was admin-

istered. The uterus was found retroverted and adherent to the floor of Douglas's cul-de-sac. The cervix was rigid and but slightly patulous. In view of the existing peritonitis, we concluded that it was best that I should endeavor to remove the contents of the uterus without a further attempt at dilatation, fearing rupture of adhesions and increased inflammatory action. I passed the wire loop of the écraseur through the os, and by careful manipulation luckily succeeded in guiding it over the tumor and up to its attachment. Drawing upon the wire, it closed around the pedicle and severed it. The tumor was seized with a volcella forceps and delivered. The index finger could now be passed into the cavity of the uterus. The pedicle was situated on the posterior wall near the fundus. The tissues at that point were soft and friable, but the remainder of the surface of the uterine cavity appeared to be free from disease. The stump was cauterized with nitric acid, and a two-grain opium suppository placed in the rectum. Convalescence was rapid and satisfactory.

On section and close examination the specimen very much resembles placental tissue, and the microscope shows typical placental villi in its structure. It is the *Placental Polypus* described by C. Braun in 1851, and somewhat resembles the *fibrinous polypus* of Kiwisch who thought that these polypi might arise from long persistent hemorrhage, a kind of apoplexy of the womb, a large coagulum forming, the upper part consisting mostly of fibrin and adhering by a stalk to the uterine wall, whilst the lower consists of red, soft coagulum, having a coat of firm fibrin. Scanzoni does not admit this view. He contends that these are cases of abortion, and would, therefore, fall under the class of placental polypi (Barnes). My own experience agrees with that of Scanzoni. There polypi cause profuse metrorrhagia and sometimes, as in this case, blood poisoning.

This case furnishes another strong argument in favor of the entire removal of the decidua or placenta after abortion. Who can tell how many lives are lost, or in how many cases the health is undermined by a neglect of this procedure? Death would inevitably have occurred in this case if the uterus had not been emptied. The patient may suffer for months or years as a result of neglect. In this instance the fault was in the patient, for she had been properly advised by her physician. It is true that many cases escape without serious injury, but that does not prove that the principle and practice of immediate removal is not always the safe one, for here is a case where a neglected abortion had apparently passed off safely, but it almost destroyed the patient's life a long time afterward.

Malignant disease was properly suspected from the rapid development of such grave symptoms, from the general cachectic appearance of the patient and from the sensation conveyed to the finger when touching the growth *in situ*. But when it was found that it had a limited point of attachment and that the uterine cavity was healthy at all other points, this hypothesis was weakened, and when more careful examination of the specimen and investigation with the microscope showed it to contain placental villi, its benign character was assured.

Dr. Montgomery remarked that in cases in which partial dilatation of the uterine canal had been accomplished before the patient presented, the best instrument to continue the dilatation is the mechanical urethral dilator of Dr. A. H. Smith.

Hair-pin in the Uterus.—*Dr. B. F. Baer* exhibited a hair-pin removed from the uterine cavity of a patient sent to him by Dr. Pancoast, of Camden, N. J. The woman believing herself to be pregnant, had tried to produce an abortion by inserting the pin by grasping the points and inserting the blunt end. The patient had obtained a view of the parts in a mirror placed upon the floor. The presence of the pin was readily detected by the uterine sound. He at first thought of dilating with tents, but the patient being greatly alarmed and very importunate, he used the steel dilator. One point of the pin became imbedded, in its descent, in the tissues of the cervix and required dissection to release it.

Dr. Wharton Sinkler exhibited a hair-pin removed from the vagina of a patient who had tried to introduce it into the uterus to produce abortion. She had failed in her purpose and had also failed to remove it from the vagina. The doctor found the points of the pin widely separated, presenting downward and hooked into the walls of the vagina. By bringing the points close

together the pin was removed without difficulty. It had been in the vagina for some time.

Dr. Montgomery stated that while a student, he had seen a hair-pin removed from a vagina. It was thickly encrusted with a calcareous deposit.

Editorial.

THE CHOLERA IN PARIS.—The sounds of alarm from Naples had hardly died away before a cry of danger arose in the very centre of the Old World's civilization—Paris. So that Koch's prediction of the wide spread of the epidemic seems to be meeting with its realization. Italy, France and Spain have been visited by it, and where it will stop no one can now tell. The first death occurred in Paris on November 6th; on the succeeding days there were 14, 33, 69, 98, 89, 81 and 75, making a total for eight days of 460—a daily average of nearly 58. On the 10th instant the municipal council appropriated $20,000 to meet the expenses of the sanitary council in dealing with the epidemic, and $10,000 additional for the relief of families in which it had made its appearance. The unhealthy quarters of the city were alone affected, and although the hospitals soon became crowded, no panic has as yet been reported. The schools continued in operation, as well as places of amusement, which are reported to have been well patronized. Many cases are reported among the troops at the barracks. Although no excitement prevailed, the visitors are reported to have left the city, and some sections of it, where people of means reside, are reported to have been almost deserted. On the 14th the council voted an appropriation of $10,000 for the furtherance of sanitary measures in private houses. A frost is reported to have occurred on the night of the 14th, which it was hoped would have the effect of mitigating the epidemic, and the latest reports (of the 17th and 18th) seem to have justified this hope, although there is a rather suspicious cutting short in the later telegrams.

There are reports also of the disease having appeared at Brussels and Halle, and 187 cases were said to have occurred in London on Friday of last week; but these reports lack confirmation.

Meanwhile measures of protection are being taken by our own and other countries. The Secretary of the Treasury has laid an embargo on rags from all infected ports, and the French, Italian and Mediterranean ports generally are declared to come under this designation. Our consular agents have been ordered to inspect all vessels sailing to this country from London, Liverpool and Paris.

The gay Parisian metropolis seems to be destined to a dull season, and the return of spring holds out anything but a bright prospect to it. Altogether we seem to be on the verge of one of those periodical visitations which, at intervals of every few years, appear to be inevitable, as no precautions as yet discovered are to be relied upon with confidence for their prevention. The best than can be said is—in the language of the State Board of Health of New York—that "experience has shown that cholera-poison does not extend where no filth favors its multiplication, and that the only way to prevent its march is to remove all sources of pollution of soil, air or water. In excremental contaminations especially lies the greatest risk, and all such conditions must be at once removed."

THE GONORRHŒAL GERM.—The question of the germ origin of gonorrhœa continues to attract attention, and the number of experimenters engaged in elucidating it is increasing. One of the latest contributions to the subject is that of Welander, of Copenhagen, who found the "gonococci" of Neisser in all the cases of gonorrhœa which he examined, viz: 129 acute and 15 chronic cases in men, and in 79 (urethral) cases of women; they were never present in non-specific discharges. The source of 25 of the specific cases was traced to the persons from whom they were contracted, and in the discharges of these persons also gonococci were found. The secretions of balanitis—containing no gonococci—was introduced into the urethra five times without result. Vaginal secretions also containing various forms of micro-organisms were inoculated without success; among others the secretion of a virgin, aged 14, in which there were found spherical and bacilliform organisms was employed in in the urethræ of three men without effect; also a fœtid purulent discharge containing bacilli in large quantity and in active movement. Finally three women were selected

the urethral discharge of whom contained gonococci, but the vaginal secretion none; the vaginal discharge of these produced no effect upon the urethræ of three men, whilst the urethral discharge produced in the same men as well as in a fourth, in two days a purulent discharge containing the "gonococci" in large quantity. Notwithstanding the very strong evidence which these observations furnish of the etiological significance of the "gonococci", Welander hesitates to accept them as conclusive, having failed to cultivate the organisms, and being unable to accept as conclusive the experiments of others as to their capability of being cultivated. His views in this respect present a striking contrast to those of Dr. Sternberg, alluded to a short time since, for the latter reverses the order having cultivated but not succeeded in inoculating.

Koch on the Power of Drugs to Arrest the Development of the Cholera Bacillus.—Koch, from his experiments to ascertain the relative power of drugs to stop the development of the cholera bacillus, brings out the following facts: Iodine in solution of 1 to 4,000 has no effect on on them, while alcohol in the strength of one part to ten; sulphate of iron, 1-50; alum, 1-100; camphor, 1-300; carbolic acid, 1-400; oil of peppermint, 1-2,000; sulphate of copper, 1-2,500; quinine, 1-5,000; and corrosive sublimate, 1-100000 were competent to arrest their development. These facts with reference to quinine and corrosive sublimate, are especially noteworthy, as these drugs have proved, clinically, of value in the treatment of cholera. They also show that iodine must prove useless when used on this principle, because of the very small amount capable of being introduced into the system.

Koch finds that the cholera microbe differs also from other pathogenic bacteria by being destroyed by drying, and as the result of further experiments on this point, it was found to be incapable of passing into a permanent state. In this fact he finds further evidence to support his opinion that this microörganism is not a true bacillus, but is closely allied to the spirillum; and adds that the absence of the permanent state coincides with the experience of the etiology of cholera. The deduction, therefore, is the early annihilation of the disease by preventing its spread through infected water and other material presenting conditions favorable to the life of the germ.

Correspondence.

Baltimore, Nov. 13, 1884.

Editor Md. Medical Journal:

A few words in the way of explanation are due to your correspondent "Artium Magister," to yourself, and to the American Academy of Medicine.

The American Academy was organized as an association of college-bred men, distinctively, with a clearly-defined specific aim—educational reform. If it be regarded as exceptional in that its membership requires a special qualification, it is at least measurably analogous to the associations of specialists in neurology, gynecology, etc., which claim and receive professional commendation and encouragement. It is not visionary or quixotic, but proposes to accomplish its object in available ways and by practical methods. There is nothing in the character or conduct of its members to warrant the occasional intimation that it is a "pharisaical mutual admiration society." It was not surprised by opposition to its radical feature, and it did not expect to escape misunderstanding and misrepresentation. It anticipated and answered the objections which have been urged against what is termed an arbitrary line of exclusion, but this is neither the time nor the place for recapitulation of these answers.

Your correspondent quotes from your editorial language that "the A.M. and A.B. degrees no more indicate the status of the scholar than the M.D. degree does that of the physician." Unfortunately, this is too true, yet if the truth as to the former be so discrediting, how much the worse for the actual value and the real significance of the M.D. which, under our present system, is so easy of attainment. "Artium Magister" says that "a classical education is not essential to the attainment of the highest professional eminence, and the possession of the degree of A.M. or A.B., as a test of this unessential distinction, is perfectly worthless." Be this as it may, these degrees imply a course of preliminary training, the helpfulness of which in a subsequent medical course cannot be ignored. The necessity for such helpfulness is ex-

hibited in many familiar ways, perhaps in none more conspicuously than in the blundering reports of causes of death that are transmitted to municipal health offices for registration. It is not impaired by the fact that men of genius, or uncommon ability, or extraordinary energy and incessant application, rise to eminence in spite of the lack of early instruction; it is strengthened by their admissions of the inconvenience and disadvantage of such deficiency. The American Academy adheres to the conviction that preliminary education is indispensable, as a rule, in the promotion of the highest efficiency. It does not presume to dictate whether academic training shall be classical, or scientific, or what. It only insists on such a disciplinary course as will best subserve the advancement of the medical studies which follow. It believes that academic degrees should only be conferred where they are thoroughly deserved. It not only holds the same view as to the medical degree, but it goes farther. Not altogether satisfied with favorable decision by college professors after the final examinations, it demands that the graduate be subjected to the additional and the severer handling of a sternly impartial State Board for a licentiate's degree. Of course, the preliminary collegiate training and the board examination, if made compulsory by statute law, would decrease the number of medical students—now largely in excess of public need—proportionately diminish the classes, and correspondingly reduce the fees. Hence a very natural opposition from the college faculties. "Artium Magister" adverts to the career of the Academy up to this time as "nine years of almost fruitless existence." Aside from the fact that it is still in its infancy, why fruitless? Because its foes are those of the household. The Academy can only accomplish its mission through State legislation. What chance of success can it expect in any effort toward the enactment of appropriate laws in every State in the face of such an obstructive force? It must first win over the opposition by ample public or private endowment of every professor's chair, so ample that it will make no difference to the lecturer, pecuniarily, whether the class number five or five hundred. That, it seems to the writer, is a consummation as devoutly to be wished by every medical teacher as it is by the American Academy.

Your correspondent say that "many thoroughly educated and highly cultivated" medical men are debarred from membership in the Academy "because, forsooth, they cannot write A.B. or A.M. after their names." If he had noted the proceedings during the recent sessions in Hopkin's Hall, he might have learned that a motion, which had been carefully considered by the Council, was offered and unanimously adopted for revising the sections of the Constitution embodying the restrictive feature complained of, and for so amending them a year hence as to provide for an associate membership. Hereafter the portals will be opened to those who are in sympathy with the objects of the organization. It has been greatly embarrassed by exclusion of leading members of the profession who have been free and frank in the expression of their desire for coöperation. That source of embarrassment removed, may not the Academy reasonably hope to earn in the future the good opinion of "Artium Magister?"

C. C. Bombaugh, M.D.

Book Notices and Reviews.

Manual of Chemistry: a Guide to Lectures and Laboratory Work for Beginners in Chemistry. A Text-Book, especially adapted for Students of Pharmacy and Medicine. By W. Simon, Ph. D., M.D., Professor of Chemistry and Toxicology in the College of Physicians and Surgeons, Professor of Chemistry and Analytical Chemistry in the Maryland College of Pharmacy, Baltimore, Md. With sixteen illustrations on wood, and seven colored plates, representing fifty-six chemical reactions. Publishers: Henry C. Lea's Sons & Co., Philadelphia.

This book supplies a want long felt by students of medicine and pharmacy, and is a concise but thorough treatise on the subject. The long experience of the author as a teacher in schools of medicine and pharmacy is conspicuous in the perfect adaptation of the work to the special needs of the student of these branches.

After the fundamental principles of matter, and the principles of chemical combinations have been briefly considered, the elements, and their compounds which are

of practical interest, are taken up; all chemicals mentioned in the U. S. Pharmacopœia being included.

Then follows a chapter on analytical chemistry, with colored plates, beautifully executed, illustrating the resulting precipitates of various reactions. These plates form a novel and valuable feature of the book, and cannot fail to be appreciated by both student and teacher as a help over the hard places of this most practical part of the science.

The chapter on organic chemistry contains the principles of combinations, together with an account of those compounds most likely to be met with in pharmacy and medicine; in fact as much of this highly developed branch of chemistry that the undergraduate has the time to consider. Physiological chemistry is treated of in the last chapter with the terseness that characterizes the book. Here also is given a colored plate illustrative of the reactions met with in the examination of urine.

The book deserves great success.

A Manual of Dermatology. By A. R. Robinson, M.B., L.R.C.P. and S., Edin. Prof. of Dermatology at the N. Y. Polyclinic; Prof. of Histology and Pathological Anatomy at the Woman's Medical College of the N. Y. Infirmary; Attending Physician to the Demilt Hospital, Skin Department, etc., etc. Bermingham & Co., New York and London.

This is one of the volumes of the "Bermingham Library," and is a creditable addition to our literature of skin diseases. The author, while regretting that he has been compelled from want of space to curtail so much that is important regarding histology and treatment, claims it to be fairly concise and complete; intended as a basis for a much larger, more pretentious and more original work to appear in the future.

BOOKS AND PAMPHLETS RECEIVED.

Medical Diagnosis: A Manual of Clinical Methods. By J. Graham Brown, M. D.; Fellow of the Royal College of Physicians of Edinburgh; late Senior President of the Royal Medical Society of Edinburgh. Second Edition. Illustrated. Bermingham & Co., New York and London. pp. 261.

The Principles and Practice of Midwifery, with some of the Diseases of Women. By Alexander Milne, M. D., Ex-Vice-President Edinburgh Obstetrical Society; Member of the Gynæcological Societies of Berlin and of Boston; Author of Manual of "Materia Medica and Therapeutics," etc. Second Edition. Illustrated. Bermingham & Co., New York and London. pp. 349.

Lectures on Diseases of the Rectum, Delivered at the Medical Department of the University of the City of New York. By J. Williston Wright, M. D., Prof. of Surgery. Bermingham & Co., New York and London. pp. 170.

The Physicians' Visiting List for 1885. (Lindsay & Blackiston's). Philadelphia: P. Blackiston, Son & Co.

The Medical Record Visiting List, or Physicians' Diary for 1885. New York: Wm. Wood & Co.

Transactions of the Texas State Medical Association. Sixteenth Annual Session. Held at Belton, Texas, April 22-25, 1884.

On the Development of Physiological Chemistry, and its Significance for Medicine. An address by Prof. Felix Happe-Seyler. Translated by T. Wesley Mills, A. M., M. D., Demonstator of Physiology, McGill University, Montreal, Canada.

Notes on the Treatment of Trachoma by Jequirity. By Leartus Connor, A. M., M. D., Ophthalmic Surgeon to Harper Hospital, Detroit, Mich.

Mumps as a Cause of Deafness. By Leartus Connor, A. M., M. D., Ophthalmic Surgeon to Harper's Hospital, Detroit, Mich.

Miscellany.

Chapois on the Resolving Action of Calomel in very Minute Doses in the Treatment of Pneumonia. (*Bull. Gen. de Thérap.*, July 30, 1884.—The value of this means was suggested to the author by his experience with a case of pneumonia in a child twelve years of age, in which blisters, leeching, and other means of treatment had been unavailing. The eighteenth day of the disease had been reached and still resolution had not begun, nor had the fever abated. It then occurred to him to try the administration of calomel, in doses of two milligrams, every hour.

Twenty-four hours later the patient was revisited, and was found to have a moist skin and a pulse of eighty per minute. The tongue was also moist and a sub-crepitant *râle redux* could be heard over the affected lung. Recovery followed without interruption. The same treatment was subsequently used by the author in many cases of pneumonia, at all ages, with complete satisfaction. The phenomena which usually follow the use of this agent for twenty-four to forty-eight hours are the following: Moisture of the skin, then of the tongue and the mouth; next a diminution of body heat, and of the sense of oppression. After fifteen or twenty doses have been taken there may be a fluid evacuation of the bowels. The author does not claim that calomel is a specific for pneumonia, and in some cases other remedies will answer equally well. The advantage of the very small doses is that a different end is sought from that which is manifest when purgative doses of calomel are given, the effect of the latter being to prostrate the individual already greatly weakened. Given in such small doses absorption is favored, the salivary glands, the liver, the intestinal, and other mucous glands are stimulated to healthy action.—*Archives of Pediatrics.*

Althaus on Locomotor Ataxy.—Dr. Julius Althaus (*Brit. Med. Jour.*, Oct. 11), has been led by long continued observations to distinguish three periods in the development of the ataxic stage of tabes: 1. The initial period in which the ataxy is so slightly marked that a skilled exploration is required to discover the symptoms. 2. The truly ataxic stage in which the peculiar walk known as the ataxic gait is observed. 3. The period of muscular madness, in which even the typical ataxic gait is no longer possible, and muscular action, as far as it still exists, is in utter confusion.

He describes a symptom of the disease which he has not seen mentioned in any treatise on this disease, viz: a considerable difficulty in walking backwards. This may be witnessed even when there may be very little or no trouble in walking forward. The patient's heels seem to catch the ground; he dare not move for fear of falling, and if he succeeds at all in walking backwards it is in a peculiarly halting and odd fashion, which at once attracts attention. This symptom is present in the majority of cases.

Dr. A. also discusses the pathology of the affection. He dissents from the views of Erb and Leyden, the two principal ones now held by authorities, and after careful consideration has adopted one, of which the following is the briefest expression: Locomotor ataxy is caused by an interruption of the paths between the posterior roots and the central ganglia of the brain through sclerosis of the posterior columns, and static ataxy is in its turn brought about by an interruption of the paths between the posterior roots and the cerebellum, through sclerosis either of Goll's columns or of the direct cerebellar strands.

Abscess of Lung Cured by Incision and Drainage.—*Mr. Teale* (*Lancet*) reports a case of abscess of the lung thus cured. A man, æt. 54, had had pleurisy for some months and it was determined to tap his chest. The puncture was made low down on the right side; only a few drops of clear, straw-colored fluid escaped. Another puncture was made higher up which gave exit to some very offensive fluid, and after some difficulty, to a pint of pus. Opening and drainage was now determined on. Accordingly, an incision was made a little below and in front of the angle of the scapula; no pus escaped until the lung was punctured. The opening in the lung was enlarged to admit the finger, when two pints of most fœtid pus escaped. A large drainage tube, six inches long, was inserted, and the cavity syringed out with weak carbolized solution and the chest encased with carbolized tow. For several months the condition was critical, symptoms of septicæmia prevailing. In four months the wound had healed and in nine months the active life of a solicitor was resumed.

Specific Directions for Preventing Cholera.—The five points to be looked after in attempts to prevent cholera, as laid down by the Illinois Board of Health, are: 1. The condition of the water supply; 2. The disposition of the night-soil, garbage and sewage; 3. The cleansing of streets, alleys and other public places; 4. The supervision of food supplies, and of market-places, slaughter-houses and similar establishments; 5. The general sanitation of every house and its surroundings.—*Record.*

Medical Items.

The Peabody Institute Library, of Baltimore, now contains 80,700 volumes.

Dr. James A. Reed, Superintendent of the Dixmont Insane Asylum, died of Bright's Disease Nov. 6th.

By the will of the late Mrs. L. J. Kowles, the sum of $25,000 is bequeathed to the City Hospital, Worcester, Mass.

A Sanitary Convention will be held at East Saginaw, Mich., on December 2d and 3d, under the auspices of the State Board of Health.

Dr. Alexander H. H. Sommers died October 20th, at Great Falls, Montgomery County, Md., from a dose of ether taken by mistake, æt. 50.

A legacy of $300,000 for the establishment of a Training School for Nurses, under the control of the University of Pennsylvania, will soon be available.

On October 10th the sum of $22,000 was distributed among the hospitals and dispensaries of London, being the proceeds of a fête held at the International Health Exposition.

Dr. Spicer Patrick, a leading citizen of Charleston, Kanawha County, West Virginia, died recently, aged 90 years. He had represented his State several times in the Legislature.

The Clinical Society of the New York Post-Graduate School is the title of a Society recently organized in that city. It is composed of the professors, other teachers and the matriculants of the school.

The patients in Bellevue Hospital, New York, were treated to a sumptuous dinner, served by Delmonico, on Tuesday, November 18th. It was given them by Mrs. Astor in honor of the occasion of the marriage of her daughter.

Dr. Attila E. Stein died at his residence, in this city, No. 149 Eden street, on Sunday, Nov. 16th, aged 46, of consumption. He was a graduate of the University of Maryland, 1868, and was a man of very considerable literary and professional attainments.

The notorious Dr. Hale, of Washington, well known to the Health Officers of West Virginia and Ohio, was forced, on the 25th ult., to disgorge a $100 fee which he had received from a colored man in Washington to whose son, a consumptive, he had guaranteed a cure.

The motion for a new trial in the case of Dr. James D. Pitts, convicted of murder in the second degree in killing Dr. Littleton T. Waller, on Tangier Island, Eastern Shore of Virginia, May 17, 1884, was overruled. Dr. Pitts has been sentenced to eighteen years in the penitentiary.

Dr. Samuel M. Bemiss, Professor of Theory and Practice of Medicine in the University of Louisiana, and one of the best known physicians in the South, died at New Orleans, November 17th. He was for many years editor of the *New Orleans Medical and Surgical Journal*.

Messrs. J. H. Chambers & Co., St. Louis, Mo., will publish the *Annals of Surgery*, a new monthly journal devoted to surgical science and practice of medicine, edited by L. S. Pilcher, M.D., of Brooklyn, N. Y., and C. B. Keetley, F. R. C. S., of London, Eng. The first number will appear January 1, 1885.

St. Vincent's Hospital, on Linden avenue, has been sold, and will be torn down to make room for private residences. It was purchased by Sisters of Charity in 1840; was first used as an insane asylum, then as an asylum for inebriates, and for the last nine years as a general hospital. It was formerly known as Mt. Hope.

Prof. Virchow recently exhibited to the Berlin Medical Society a microcephalic girl, æt. 14, of normal figure, but whose head was scarcely as large as a man's firt. Her face is not larger than that of a newborn child, and her features resemble those of a bird of prey. Her intelligence is not beyond that of a six months' child.

A bill in equity was filed on the 17th of November, in the Circuit Court of Baltimore, by Messrs. Findlay & Brinton, attorneys for Drs. Monroe and Ellis, praying an injunction to restrain Drs. Byrd and others from using the name of the Baltimore Medical College, or carrying on a school of medicine under the corporate power thereof. Bond was fixed at $2,000.

Original Articles.

DEMENTIA PARALYTICA, WITH RECOVERY OF CASE.

BY JOHN W. HOCKING, M.D.,

Of Govanstown, Md.

Recovery from Dementia Paralytica is so uncommon that I believe the following case, under my charge in 1882, of sufficient interest to place on record.

N. R., æt. 29, a laborer, unmarried, phlegmatic temperament, finely developed physique, strictly temperate, continent, and of regular habits, has enjoyed robust health since childhood.

His parents are still living, at age 65, and they, with three brothers and three sisters, ranging in age from 26 to 40 years, are, and always have been, free from mental diseases. Grand-parents on both sides died at ages ranging from 56 to 86 years, without history of mental trouble.

In February, 1882, the patient being out of employment at the time, was observed to be more than usually quiet, was moody, kept apart from the family, confined himself to his room, read and smoked incessantly, and complained much of headache. He went out but little. One evening he visited a saloon and drank to intoxication. During this debauch he had an epileptoid fit. This occurrence depressed him still further. Towards the close of April a series of meetings were conducted under the auspices of "Women's Christian Temperance Society." These he attended regularly, and from being depressed and gloomy became loquacious, spoke in a loud voice, advocated strongly the work being done by the society, expressed much sorrow and regret for his past sinful life. He was restless, feverish, active, excited, and slept but little. In this state he continued for a week, when undoubted evidences of mental disease were observed. He would rise in the middle of the night, dress hastily and leave the house without his hat, returning in the early morning bathed in perspiration, weak and exhausted, feet blistered from the prolonged and rapid journey just completed. These journeys were made in search of "people" of whom he now spoke so frequently. To the privations and hardships thus endured he seemed insensible. On returning one morning, he approached a servant girl in the house and made improper proposals to her, and saying Jesus Christ had directed him to do so. He made no effort to force her to comply with his wishes when she declined, but told her she was doing wrong, and walked away. Hallucinations now became more frequent and varied; he was oppressed with grief, anxious and melancholy. To-day the "people" want to get hold of him, to-morrow they say his feet stink, or that his whole body emits a foul odor; and, if permitted, he would wash his feet half a dozen times during the day and change his clothing as often. On entering a room he would at once close all the blinds to keep the "people" out, or would open the stove doors in order that disagreeable odors might be carried off. At times there were ebullitions of wrath at fancied taunts and insults, after which he would sob and cry as if in deep trouble. Again he would sing at the top of his voice, or would dance for half an hour without evidence of fatigue. Or if sitting down would spring up suddenly, stretch himself at full length on the floor and then as hastily resume his seat. Aimless acts of this kind apparently gave him pleasure, although he could give no satisfactory reason for their manifestation. Simultaneously with these symptoms there were evidences of derangement of digestive function and of nutrition. The appetite was variable, at times voracious and again no desire for food.

The countenance was flushed, vacant and expressionless. Efforts at speech were attended by twitchings of the muscles of the face. His sentences were disconnected from the omission of words. The labials were pronounced with difficulty, owing to paresis of the muscles of the lips and tongue. The voice changed in tone and quality. Eyes slightly congested, headache constant, the special senses of taste, smell and hearing were perverted. He kept his ears full of cotton to deaden sound. There was also anæsthesia of the nerve of taste (agnesia). As an evidence of this he would swallow ℥ss. chloral hydrat. dissolved in ℥j. of water, just as readily as the same amount of pure water. There was also hyperæsthesia of the olfactory

His face felt hollow, his head a mere shell of bones. The tongue was coated and protruded with difficulty and trembling, notwithstanding his efforts to control it. The

bowels were constipated. He early had extravagant ideas of his own strength; would place himself in the middle of a road, and on the approach of a horse and wagon would wave his hand majestically to stop it, saying at the same time that with one hand he could pitch the team off the road. On one occasion, having escaped from his home, he stepped on the railroad, in front of a slowly-moving locomotive and train of cars, evidently intending to throw the locomotive off the track. The engineer saw him in time to stop his engine, when our patient moved off with a superior air, possessing a more exalted opinion than ever of his wonderful strength. His memory for recent events was poor, while events of childhood were readily reproduced and laughed over. His attention could not be commanded for any length of time; questions had to be repeated, and then the answer came slowly and hesitatingly, after which he soon became absorbed in the workings of his own mind. He required constant watching. On one occasion, about the middle of July, some of the usual precautions having been neglected he made his escape during the night, and walking to a village four miles distant, he approached a house, and, after creeping stealthily about for some time, tried to effect an entrance through the back door, when he was confronted by the man of the house (who had observed his approach) who discharged a load from a revolver, the ball passing through the patient's hat. Just as the man was about to shoot again the patient grasped the muzzle of the weapon, elevated it so that the ball passed through the lapel of his coat, grazing the right side of his neck just above the clavicle. He then ran away and returned to his home. Of this occurrence he gave fragmentary accounts.

Remission in all the symptoms occurred occasionally when they returned in aggravated forms. The remissions lasted for three or four days to one week. The symptoms invariably reappeared in the evening.

In the hope that a complete change in all the surroundings might bring relief, he was, in charge of his brother and myself, taken to Baltimore, New York and Boston, from his home in West Virginia, making the journey to Boston by rail and returning by water. His condition, however, remained the same, possibly aggravated by the excitement. In New York he declared he was shadowed by a man who was paid three dollars per day and board for watching him during his visit to that city.

After returning home his condition grew steadily worse. The facial muscles became more and more relaxed; speech more hesitating and unintelligible; his appetite failed entirely; so that he had to be fed like a child; there was great emaciation; the gait was tottering and uncertain; paroxysms of rage increased in frequency and violence, requiring, at times, the united strength of three persons to restrain him. Meanwhile a constant war was carried on with his invisible enemies, he talking loudly and profanely. His moral sense was blunted, the urine was passed on the carpet in the sitting-room or hall-way. He was addicted to onanism, and once when detected in the act, said, "go away, this must be done."

His general condition, physical and mental, tended towards extreme feebleness, and his case now (in Oct.) seemed hopeless. At this point, when it seemed that each day must bring him nearer to the end not far away, his nurse began and continued the applications for three days, of flannels wrung out of hot water, which enveloped the entire head. Strange to say there came a gradual remission in the downward course of the disease; natural sleep, sound and refreshing, such as had not been experienced for months, was enjoyed the first night after the applications of the hot flannels had been made. He awoke the next morning free from illusions and hallucinations. The appetite improved, the countenance regained its natural appearance, the voice resumed its natural tone and quality, he conversed sensibly, and though cross and ill-tempered at times, improvement was steady and progressive so that by the 15th of December, eleven months from the first evidences of the disease, his restoration to health was completed, and up to this writing, November 20th, 1884, he has not exhibited one untoward symptom, while he has resumed his former position in life with family and friends.

As to the treatment: In May, when pronounced symptoms of insanity were first observed, bromide of potassium was given in 3ss doses to procure sleep. It fulfilled its purpose for a short time only, when chloral and morphia were substituted and

proved invaluable throughout the course of the disease.

The bromide, with bromhydric acid, was given during the day, and chloral and morphia at bed-hour. The nucha was successively cupped and blistered and sponged with ether. An occasional purgative was given to relieve constipation.

Nux vomica and capsicum were given as stomachic tonics; and, after subsidence of maniacal symptoms, dil. phosphoric acid, in gtt.xx. doses after meals.

The important thing in the treatment of this case was sleep. Without it the patient must have exhausted his strength in a very short time. To the applications of heat and moisture to the head and nightly doses of chloral and morphia, with careful alimentation, if to therapeutics at all, must be attributed the recovery in this case.

THE LEGAL CONTROL OF MEDICAL PRACTICE BY A STATE EXAMINATION.*

BY JOHN B. ROBERTS, M.D.,

Professor of Anatomy and Surgery in the Philadelphia Polyclinic.

It is my intention this evening to briefly review the advantages that would accrue to the public and the medical profession by the enactment of a law placing the control of medical practice in the hands of a State Board of Examiners. As is known to many of you, a person who desires to practice medicine in Germany must pass a governmental examination. The students study in universities, and take degrees, but such degrees do not confer the right to enter upon practice. The health and lives of the citizens of the empire are believed to be too valuable to be imperiled by the acts of ignorant physicians. Hence, although the universities themselves are under the supervision of the State, the candidate for practice must, in addition to his university examination for a degree, pass a governmental examination for license to follow professional work among the people of his vicinity. He is not a legally qualified practitioner until this is accomplished.

The recklessness with which medical legislation has been neglected in this State will be apparent when I say that the medical schools are under no State or Federal supervision whatever. They have entire control of the time and character of studies required from the intending practitioner, examine him upon the same, and confer the medical degree, which is at once accepted by the authorities as evidence of sufficient knowledge and skill to entitle the possessor to practice medicine, surgery and obstetrics in the community. Still further, to encourage wholesale and unrestrained manufacture of physicians, the "doctor manufactories" are, I believe, even exempt from taxation.

Until the year 1881 there existed in this Commonwealth no law whatever regulating medical practice. At that time the law to provide for the registration of all practitioners of medicine and surgery was enacted by the General Assembly of Pennsylvania. It effected much good, and was a distinct step forward, though it has, among other minor defects, the weakness that the possession of a genuine diploma is taken as evidence of knowledge.

As long as the medical schools of the United States are dependent for prosperity upon the number of fees received from pupils, and as long as examinations by the faculties who receive these fees are the sole test of skill, a diploma, even from the highest grade institution, carries with it little value as a diagnostic proof of professional learning. The old Latin proverb has it: "Caveat emptor," "Let the buyer beware." I say, "Caveat æger," "Let the sick man beware," if he believes that the fact of graduation from a renowned college confers intelligence and skill. The placard, "No reasonable offer declined," usually tells the buyer that an inferior quality of goods is to be expected. Would that many colleges had the honesty to display a similar escutcheon over their portals, reading "No reasonable ignorance rejected."

The step I advocate to-night is the creation of a Board of Medical Examiners, under State jurisdiction, which shall examine all persons desiring to enter upon practice in this State, after January 1, 1886, without regard to when, where or how they obtained medical education. If such an examination by non-interested persons shows the proper qualifications, the candi-

* Read at the Fourth Stated Meeting of the Medical Jurisprudence Society. October 13, 1884.

date is to be furnished with a certificate, and is then registered in the Prothonotary's office as heretofore. Let the medical schools teach, examine and grant degrees as at present; but let no one practice in this State who has not been examined by those who have no interest in passing or rejecting him. In other words, merely substitute for the diploma the certificate of the State Examining Board, as the requisite of registration.

The greatest advantage derived from such a law would be the protection of the public health from ignorant physicians. Bear in mind that I refer now, not to Indian medicine men, negro herb doctors and other charlatans, but to ignorant physicians, graduates of recognized and reputable schools of the United States and other countries; such as are duly armed with beautifully engraved diplomas signed by leaders of the profession, and, therefore, more dangerous to the community than a whole tribe of Indian "pow-wow-ers."

The United States government long ago adopted a similar plan of examining candidates for its army and navy medical services; so that at the present time its soldiers and sailors, even in distant territories and seas, have an average benefit of better educated physicians than citizens of New York, Philadelphia or Boston. An army or navy surgeon receives his education in any school, but he enters the Federal service only after an examination by a board who had nothing to do with teaching him, and who have no pecuniary interest in passing ignorant candidates.

A second advantage of the plan advocated is the improvement in registration that would take place. By the present law, persons who were in continuous practice for ten years prior to its enactment were allowed to register without diploma and without examination. Such persons, if any still reside in the State unregistered, or if any new ones come into the State, would by the new law be required to show their qualifications for practice by examination. This would be a gain, as it would exclude a certain proportion of uneducated persons.

Section 4 of the Registration Law requires persons coming into this State with diplomas from other countries or States, "to lay the same before the faculty of one of the medical colleges or universities of this commonwealth for inspection, and the faculty, being satisfied as to the qualifications of the applicant and the genuineness of the diploma, shall direct the dean of the faculty to endorse the same, after which such person shall be allowed to register." This imposes a considerable amount of work upon the medical schools, who, doubtless, would gladly be excused from this unpaid and uncongenial labor; for to reject the diploma or graduate of a neighboring institution lays the school open to unjust criticism. Moreover, the law does not state that the said colleges should be schools for undergraduates. Some months ago application was made to me, as Secretary of the Philadelphia Polyclinic and College for Graduates in Medicine, for certification of a man's qualifications for registration under this act. Undoubtedly, post-graduate medical schools were not intended by the law, and I declined to act in the matter. Moreover, there are loopholes in the Registration Law, by which punishment for practicing illegally can be escaped. A notable case occurred, six or seven months ago, in Clearfield county, and is mentioned in an editorial published in the *Polyclinic* for March, 1884.

An exceedingly important result of the establishment of a State Examining Board in Pennsylvania would be the elevation of the standard of education in the medical colleges of the country. Many citizens and prospective citizens of the Keystone State study in the colleges of New York, Maryland, Ohio, Michigan and other States. As soon as it is known that no one can practice in this wealthy commonwealth unless he passes the State examination, such persons will study in the highest grade schools, and in those whose graduates show the smallest percentage of failure before the Pennsylvania Examining Board. Hence, if our schools are the best equipped and supply the best education, men will not pay their money to the teachers, boarding-house keepers and merchants of other States, but will attend our own schools, and thus increase the business prosperity of Pennsylvania. The competition of low grade colleges, whether in this or neighboring States, would not then tend to paralyze the efforts of institutions of high educational standard. There would be no longer a premium offered for quick graduation after two years' study and a five minutes' oral examination in each of seven branches.

Another indirect advantage would be

this: that students could study in several institutions, and thus gain the benefit of hearing the foremost teachers of various schools, instead of being cognizant with the precepts of but one faculty. The former method of study is certainly the most elevating, as it broadens professional knowledge.

The division of labor resultiug from examinations being held by a non-teaching board, having committees in different parts of the State, would make it possible to hold written and manipulative, as well as oral examinations, and thus do better justice to candidates than is possible by an oral examination alone. Again, the examinations not being held all at one time of year, would further accommodate intending practitioners and lessen the labor of the examiners. As it is now, the college faculties, with great inconvenience to themselves, and often with injustice to the pupils, hurry through the examinations of several hundred students in a few days. A gentleman, now dead, who was for years a professor in a large medical school, once told me of a case where a man who failed to pass his examination was actually graduated, because of a clerical error that occurred in the hurry of Commencement time. Neither of us knew how many people owed their deaths to that accidental physician. Bright men may have been rejected by similar errors made in hasty examinations. The State Board examination would be conducted leisurely, and being partly written, would show by the records whether a man was unjustly rejected. He would also have the right to a public appeal from the report of the Board, which now he has not. The college examination is, as it should be under the present arrangement, the private business of a private corporation, and, therefore, sealed from public inspection.

Another advantage which deserves consideration, is the power of revoking a man's license to practice, which would be possible if a State Examination Board is instituted. His diploma cannot and could not be taken away, but his certificate of knowledge, character, etc., could be canceled or withdrawn by the board if he was convicted of criminal malpractice or similar crime.

The last reason for advocating the law is cogent; but to my mind deserves little attention, because it is a selfish one, which should influence us much less than those previously discussed. Such an examination would weed out and keep out of the profession those persons who, though ignorant of medical science, accept professional duties and emoluments, and thus increase the difficulty of an educated physician gaining a livelihood. There are, undoubtedly, too many physicians for the needs of the closely settled districts. Fewer doctors, and better ones, would be a boon to most sections of the State. The State examination would effect both objects. The legal profession has, I believe, certain restrictions to indiscriminate admission to the bar. Why should not the medical profession have some similar protection?

Dr. Isaac Ashe speaks of districts in Scotland where sixpenny charges are made by physicians, and says he knows of an English town of 50,000 inhabitants, where one shilling charges are made for medical advice. ["Medical Politics", the Carmichael Prize Essay for 1873, p. 33.] He quotes from the *Medical Press and Circular*, of September 11th, 1872, p. 216, the following charges adopted by a practitioner of thirty years' experience:—"Midwifery, two shillings and sixpence; advice, sixpence; consultations, one shilling." Is there a barrister in England, or an attorney-at-law in Pennsylvania, who accepts such insignificant fees for professional services? Yet the position of the medical profession in Pennsylvania is little better than that mentioned in England. The poor estimate put upon medical service is due to the overcrowded state of the profession, and the inferior quality of much medical work; both of which conditions would steadily decrease after the initiation of a State examination.

That the medical profession desires the adoption of a State Examining Board may be assumed from the recent action of the Philadelphia County Medical Society. At a meeting of the present month, in which this and kindred educational topics were fully discussed by college professors and practitioners, both general and special, the following resolutions were offered. After postponement for printing and circulation they were adopted:—

Resolved, That the Philadelphia County Medical Society believes that the status of the medical profession of this State will be elevated by the establishment of a non-teaching Board of Medical Examiners, whose certificate shall be the only one ac-

cepted by the Prothonotary's office for physicians registering after January, 1886.

Resolved, That the other county societies of this State be requested to advocate the establishment of such a Board at the next meeting of the State Society, and to discuss the matter, prior to that meeting, with the members of the general Assembly resident in their counties.

Resolved, That the Corresponding Secretary be directed to transmit a copy of these resolutions to the Secretary of each county society, with the request that immediate action be taken, and reported to this society.

Resolved, That a committee be appointed to draft a law creating a State Board of Examiners, for the examination of all persons for license to practice medicine, the said law to be presented at the next meeting of the Medical Society of Pennsylvania by the Philadelphia delegates to that meeting.

Having spoken of the advantageous action of a State Examining Board, I must hastily consider the objections that will be raised to its enactment.

It will be said that physicians living outside of this State, but near its border, are often called to attend patients in Pennsylvania. Very well; let them be examined by the Pennsylvania Board, and register in the county of this State nearest their residences. Shall a physician of New Jersey, Maryland, Delaware, New York or Ohio practice continuously in Pennsylvania, without being subjected to the same examination as residents of this State? Certainly not. Those, however, who come into the State as consultants with duly licensed practitioners of this State should, of course, be excused from the State examination. So should dentists who do not practice medicine, whether residents or non-residents of the State. In the same manner midwives, who attend the very poor in cases of confinement, should be exempt from professional examination, though they undoubtedly should be registered and give some evidence of obstetric knowledge.

A physician changing his residence within the State would merely be required to register in his new locality, but would have to pass no second examination. Nor should those now legally registered and practicing be required to pass the State examination.

It will be urged as an objection that there are physicians who desire to practice special systems of medicine, and that such a State examination would exclude these from practice. Not at all. Let the Board examine all candidates on anatomy, physiology, pathology, hygiene, surgery, obstetrics, chemistry and materia medica only, omitting theories of medical practice and therapeutics entirely from the schedule.

I have thus advocated, Mr. President and gentlemen, a measure which will, I believe, add to the wealth and prosperity of the State of Pennsylvania and elevate the profession of medicine; for whatever elevates the latter must increase the former. The wealth of a community is the health and lives of its citizens. Every useful life saved, every illness shortened, adds to the public treasury. The educated physician may do both; the ignorant physician does neither. I pray you to aid in cultivating the one and eradicating the other.

1118 *Arch Street.*

REPORT OF A CASE OF INTERSTITIAL KERATITIS IN A SUBJECT WITH PROBABLE HEREDITARY SYPHILIS.*

BY CHARLES A. OLIVER, M.D.,

One of the Ophthalmic and Aural Surgeons to St Mary's Hospital, Philadelphia.

The object in bringing this case before you, is not to evoke any unnecessary discussion as to the probable character of pathological changes, nor to give either the etiology or literature of the disease; but it is owing to the fact that this most amenable of corneal inflammations should be placed before the general practitioner in such a way that proper therapy might be employed in a manner that would soon lead to partial or entire restitution of both condition and function.

Probably many of you are aware that the disease had been recognized for many years, under various guises, such as strumous or scrofulous corneitis, keratitis scrofulosa, etc., before the genius of a Jonathan Hutchinson gave it a true causal relationship in describing it as one of the offsprings of syphilitic taint; though it is to be regretted that his enthusiasm led him too far when he as-

*Read before the Philadelphia County Medical Society, October 15, 1884.

serted a belief that "chronic interstitial keratitis is essentially an heredito-syphilitic disease." This was refuted by hosts of Continental writers, in such a positive and unequivocal manner, that all unbiased observers have been brought to the standpoint that there is a *form* of parenchymatous keratitis which is pathognomonic of hereditary syphilis. Personally, I am convinced that the case I shall bring before you, is an example of this character of the inflammation, although, in a desire not to be too dogmatic in an assertion, I have employed the qualification of probability.

May 10, 1883.—S. A. S., aged 10 years, a sallow and coarse-skinned girl of stunted growth, showing marked Hutchinson's teeth, scaphoid curve of face, superficial cicatrices at the angles of the mouth, and a prominent forehead (hydrocephaloid type of Taylor), presented herself for inflammation in both eyes. This, she said, was of two months' standing. Her parents were living, and said to be healthy. The patient was the second of a family of seven girls, none of whom, with the exception of this one, had had any eye trouble. The first child had always been perfectly healthy; whilst the second (the patient), the third and the fourth had each a rash in infancy. The fifth died of marasmus. No history of any illness in the sixth and seventh children; the younger being but eighteen months of age. The patient stated that her vision had gradually failed, commencing in the left eye, accompanied by very slight ocular pain. No periorbital neuralgia of any kind. She also complained of a swelling on the inner face of the anterior portion of her right leg; painful at night. With the right eye she saw fingers at two feet; with the left, fingers at one foot. Each cornea presented an almost uniform translucent appearance, with isolated spots of denser infiltration more generally in the periphery, and extending irregularly to the corneal summit; this condition was more pronounced on the left side. Both conjunctivæ showed slight injection of their blood-vessels, with some congestion of the deeper ciliary branches. The irides were barely visible; the position of the pupils being known by the difference in the reflected color of the corneal membrane at the points opposite. A large node on the right tibia could be plainly felt. The child was ordered inunctions of one-drachm masses of mercurial ointment, twice daily. To use a collyrium of neutral sulphate of atropia (gr. ij), three drops in each eye, twice a day. Patient to wear protective glasses, and to report at the clinic once a week.

May 17.—Better. O. D. V. = $\frac{5}{24}$; O. S. V. = $\frac{5}{60}$. Pupil of right eye was fully and evenly dilated, whilst that of the left eye but slightly so, although the mother of the patient claimed to have used the mydriatic in both. Treatment was continued.

May 24.—General condition much improved. Node on the right tibia not so painful, and possibly a trifle smaller in size. No indication of mercurial stomatitis. Right pupil the more dilated. O.D.V. = $\frac{5}{15}$; O. S. V. = $\frac{5}{60}$. Impossible to obtain accommodation with the ordinary test-types. To continue treatment.

June 7.—Left pupil was as large and as even as its fellow. O. D. V. = $\frac{5}{15}$; O. S. V. = $\frac{5}{24}$. No evidence of salivation or of local action upon the skin. No change in treatment.

June 21.—Child presented a much better appearance; cheeks fuller, with a much healthier tint of skin; lips ruddy. Mother asserted a gain in general weight; appetite improved; bowels regular; able to sleep well at night. Both pupils fully and evenly dilated; tibial node had disappeared. On account of slight tenderness of the gums, as evinced by sharply snapping the teeth together, she was told to stop the ointment; the collyrium ordered to be used twice a week; patient to cleanse her mouth thoroughly with pure water, several times daily.

July 9.—O. D. V. = $\frac{5}{15}$; O. S. V. = $\frac{5}{15}$. Ophthalmoscopic examination of the right eye showed that the disc, though plainly visible, was very grey in tint; this latter being probably partly due to the hazy cornea. The edges of the disc were somewhat obscured by coarse retinal striation, whilst its substance was seemingly thickened, as if from previous inflammation. To the temporal side of the disc could be seen numerous irregular black massings; to its nasal side, some black pigmentation. No visible splotches or hemorrhages. Marked evidence of past choroidal disturbance, as shown by the visibility of the larger choroidal vessels and black interspaces, as well as by a few isolated degenerative areas. Examination of the left eye showed that the cornea was more hazy than its fellow, and

that though the disc was not so prominent as the one in the right eye, yet it was grayer in appearance—this latter was probably due to the increased haze of the cornea. Same character of choroidal ring and irregularly broken *conus* as in the other eye; disturbance of choroid more intense: near the macular region, between it and the disc, there was a large blackish spot of pigment. Ordered the yellow oxide of mercury in vaseline (gr. ij ad 3j), to be used twice daily upon each eye, in hopes of still further clearing the corneal opacities.

Remarks.—For several reasons, the case is interesting from a clinical point of view. First, in the long-continued tolerance of large doses of mercury. For over a period of six weeks, the child was probably absorbing sixty grains of the drug daily, without the least evidence of any detrimental result. This, no doubt, was dependent not only upon account of the possible lessening of the abortive powers of an improperly nourished integument, or the more probable voracious appetite of a "lues venerea," for the metal of the god who was entrusted with the amours of Jupiter; but to certain rules that were strictly enforced and obediently followed. The child was carefully watched throughout the entire time; certain hygienic precautions pointed out to the mother; mouth periodically and properly cleansed after each meal; order given to alternate the frictions from the inguinal to the axillary regions; continuance of the instillations of atropia, even after all cessation of any appearance of its local necessity, in order to combat any tendency to a stomatitis or salivation; all allowed valuable continuance of a powerful drug during the height and subsidence of grave and destructive eye-symptoms. To be certain that she was receiving a drachm of the ointment at each sitting, the formula was so arranged that two ounces were divided into sixteen masses, and each mass was wrapped in a separate piece of oiled paper. The child was told to perform the inunctions with her naked hand for at least twenty minutes at a time, taking care to remove her gold finger-ring during the rubbing. Any form of the drug might have been used, but after some considerable trial with the other preparations, this form has been preferred to all others, for reasons of promptness and efficiency of action. The complaint of its dirtiness is of very little importance, when the great value of the material is considered.

Second, the non-employment of hot stupes to the affected organs. The use of warmth to promote an increased supply of blood to the part, did not seem to be indicated; the corneæ rapidly became vascularized of themselves, carrying off the effete material, and leaving but a residuum of local cell change, as shown by some slight opacities of a probably permanent type.

Third, the slowness of dilatation of the left pupil. It is reasonable to suppose that this want of action was owing either to the inflamed and infiltrated cornea not allowing proper endosmosis of the drug; or that a low grade of inflammatory action of the tissue of the iris existed, causing such plastic formation and cell infiltration as to prevent muscular action.

Fourth, the probability of hereditary syphilis. The family history, although imperfect in the want of positive evidence of the disease in the parents, is rendered almost pathognomonic by the order of occurrence of probable hereditary syphilitic lesions in the patient's sisters. It will be noticed that the oldest child was healthy, and that the hereditary taint, first manifested in the second child (the patient), continued to the sixth; whilst the seventh child, which was also seen by the writer, was to all appearances healthy. There can be but little doubt that the primary disease in the parents originated between the times of the births of the first and second children, upon which latter child it spent its greatest force; its manifestations dying away by degrees, until the youngest children have either been saved, or that the infection has been so slight as to render their symptoms either vague or void.

The child's past and present histories speak very emphatically of the character of the type of the disease. The rash in infancy, and the character of the onset of the eye trouble; the form and the symmetrical variety of the keratitis; the typical teeth; the characteristic countenance and stature; the superficial cicatrices at the angles of the mouth; the courseness of the integument and the tibial node; the denial of vaccination and the want of appearance of any vaccinal scar; the rapid improvement under the use of the alterative, with the almost seeming immunity of the system to the deleterious effects of the drug: are all,

to the writer's mind, conclusive evidences of the heredito-syphilitic type of the disease.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD NOV. 8TH, 1884.

(*Specially Reported for the Maryland Medical Journal*).

The President, DR. B. B. BROWNE, called the meeting to order at 8.30 P. M.

The first paper of the evening was read by *Dr. W. P. McIntosh*, his subject being

PERFORATING ABSCESS OF THE LIVER.

He exhibited specimens in illustration.

(See last No. of the Journal, pp. 55.)

DISCUSSION.

Dr. Winslow thought even a larger abscess of the liver might simulate lung troubles. Neither pain nor jaundice is always present as indicative of disease of the liver. The best sign, if present, by which a cyst can be distinguished from an abscess, is the peculiar thrill imparted to the finger when the former is palpated, and one which Dr. McIntosh had not noticed. The doctor related the case of a man 70 years of age, who first complained of diarrhœa, not much pain about the liver, and who presented few well-marked symptoms of any kind. A tumor formed about the right lower costal cartilages, an aspirator was introduced and pus withdrawn, the cavity refilled and this time it was incised, well drained, and antiseptic dressing used with a resulting cure of the abscess. The aspirator is of great use as a diagnostic means, and though it may cure small abscesses, large ones will rarely be cured.

Dr. I. E. Atkinson thought it very important for us to get rid of the idea that these abscesses are confined alone to those who reside in tropical regions. A diagnosis is often easily made, but at other times it is very obscure. He then instanced the following case. An elderly man complained of pain in the region of the liver; slight febrile symptoms showed themselves with irregular chills and enlargement of the liver, but no fluctuation. The autopsy revealed a large abscess in the diaphragmatic portion of the area which could not have been detected by palpation, and was not diagnosed during life.

Dr. Rohé spoke of a case similar to Dr. Atkinson's, in which an aspirator was introduced several times, but without drawing any pus; also of a case in which the diagnosis was assured, no pus could be drawn into the aspirator, but in which an incision caused the discharge of a thick pus.

Dr. Chambers doubted the propriety of opening into the liver by an incision unless the diagnosis of abscess was absolutely certain.

Dr. Councilman thought it all important that the sputa in cases of suspected tubercle of lung should be examined for bacilli, and that it would be a positive means of diagnosing abscess from tubercle of the lung. The clinical use of the microscope, the doctor was persuaded, was too much neglected by the practitioner.

Dr. Jones was of the opinion that the use of the aspirator was not always followed by harmless results, and in support related the case of a patient who suffered from stricture so that the urine had to be drawn with an aspirator, which resulted in the death of the individual from peritonitis, which commenced at the point of entrance of aspirator.

Dr. Latimer was in great doubt if in Dr. Jones' case, the patient did not die from his previous trouble rather than by the use of the aspirator. The doctor did not think there were any symptoms by which a positive diagnosis of abscess of the liver could be made except by a successful aspiration; the aspiration, while justifiable as a diagnostic means, would not, for many reasons, always reveal the presence of pus. A deep-seated abscess, unless very large, cannot be positively diagnosed; if superficial, we may suspect, and may be certain by a successful aspiration.

Dr. Mitchell did not think the thrill of much importance as a diagnostic means.

Dr. Tiffany had seen three cases in which the abscess of the liver opened into the lungs, in all the diagnosis could be made from one sign, namely a red brick-dust sputa, which was at times thrown out; it looked like brick-dust and corn-meal, mixed with water. He thought it a symptom never absent. It is very probable that in deep-seated abscesses the pus will tend to make its way toward the direction of the least resistance; that is toward that portion of the

liver uncovered by peritoneum. The doctor mentioned the case of an individual who was aspirated in the abdomen for the relief of dropsy, a fatal result followed from peritonitis so induced.

Dr. Sternberg was of the opinion that no danger could result from the use of the aspirator if the instrument was thoroughly freed from organisms, and thought it a very important point, and that the needles should either be heated or washed in a sol. of bichloride of mercury. The doctor had found the peritoneum of the rabbit free from any trouble, even after it had been roughly handled, and pulverized glass introduced into its cavity; but the smallest amount of septic material introduced into the peritoneal cavity will cause death.

Dr. Tiffany thought the peritoneum of animals not like those of the human subject.

Dr. Bevan exhibited Specimens of Tubercular Disease—Kidneys, Bladder and Testicles. The doctor then spoke of the case. The patient was about 35 years of age; had enjoyed good health until recently; had lost a sister from phthisis, and a brother from some lung trouble. Two years ago his trouble commenced with a pain in the region of his bladder; at one time it was necessary to give him opium, and a hot bath, in order that his urine might be voided; after this the pain was of a teasing character and the urine thick. He fell, under the care of Dr. Otis, who, being unable to enter his bladder, except by an exceedingly small instrument, a perineal section was done with marked relief. Urine showed an inflammatory condition of the kidneys. When the doctor saw him the perineal wound had closed; urine thick with albumen and casts; he complained of pain in his side, and had digestive troubles. Testicles suppurated after the perineal section. The pelvis of the kidney was filled with ammoniacal urine.

Dr. Branham exhibited specimens of scrofulous kidneys and urethra. They came from the dead-house, and he could give no history. The pelvis of one kidney was filled with caseous matter.

Dr. Councilman exhibited Specimen of Internal Hernia, with Valvulus. It was from a negro, 65 years old. The uterus was prolapsed, and the vagina with it, a band of fibrous tissue extended from the cornu of uterus to the broad ligament in which there existed, a small opening through which the entire ileum had passed; considerable dropsy of the fallopian tubes existed, and some myomata were found in the uterus. Dr. McIntosh said he had been in attendance upon the case, and from the pain thought it one of cramp-colic.

Dr. Winslow exhibited specimen, showing Fracture of Right Side of Pelvis, caused by a locomotive; also a specimen from the dissecting-room, showing a Cured Fracture of the Pelvis.

Dr. B. B. Browne exhibited two specimens of Fibroid Tumors of the Uterus, with Sessile Attachments to the Fundus, which he had removed by enucleation. The patient had suffered greatly from pain during menstruation, had become much exhausted, and been confined to her bed. Both were removed by traction and enucleation. (See Journal, Nov. 8th, pp. 11).

By request of the President, *Dr. Russell Murdoch* related several cases as showing the good results obtained from the use of hydrochlorate of cocaine in solution. In one case some prickles from a chestnut-burr had stuck into the cornea, one of them quite deeply; all were removed without pain; the operation took 13 minutes. In a second case a machinist had some hot iron burned into his cornea, which was removed with the rust without pain. The third was a case of cataract in which the local anæsthesia was perfect except when the iris was cut. The fourth was in a case of cancer of the orbit, a dry shred hung from the eye, giving much annoyance; it was removed painlessly. The doctor had noticed the drug diminish the circulation in the vessels.

Dr. Theobald confirmed Dr. Murdoch in his experience with the drug. He had slit up a canaliculus, removed a pterygium, operated upon lacerated lids, and the drug had in all cases given him good results.

Dr. Harlan had used it in five or six cases with good effect.

Dr. Woods also spoke of cases where its beneficial effect was shown.

Dr. Mackenzie had not derived much benefit from its use in the pharynx; in one case he had removed a small polypus without the patient's suffering any pain; also he had painted it once in the nostrils in a case of deflected septum, crushed the septum into position, and no pain was experienced. Instead of anæmia the doctor found the mucous membranes of nose and pharynx to become increased in redness.

PROCEEDINGS OF THE MEDICAL SOCIETY, DISTRICT OF COLUMBIA.

STATED MEETING HELD OCTOBER 22, 1884.

(*Specially Reported for Md. Med. Journ.*).

The Society met with the President, Dr. Garnett, in the chair, Dr. W. H. Taylor, Secretary.

The President then stated that by a resolution of last meeting, on motion of Dr. J. F. Thompson, the subject of

CANCER OF THE UTERUS.

was set for discussion this evening.

Dr. J. F. Thompson said he did not make the motion to discuss cancer of the uterus this evening because he had anything new or special to say on the subject, but to get some of the cases disposed of now pending before the Committee of Microscopy.

Cancer of the uterus was a most interesting and important subject for consideration. The last discussion in which he had participated, in this Society, was upon a case reported by the late Dr. Ashford, as cancer of the cervix, in which he had effected a cure by a partial amputation of the cervix. He did not think the disease was cancer. Several diseased conditions of the cervix were so much alike, clinically, that they could scarcely be distinguished from one another, yet, pathologically, they were entirely different. Dr. Smith's first specimen presented was not cancer. Many of these cauliflower excrescences were at one time non-malignant and at another time malignant, just as is the case with some little growths found in the larynx, they may take on malignant action after having existed a longer or shorter time as non-malignant. And it is impossible to tell just at what time the character of the disease may change from one condition to the other. Partial extirpation of the uterus in case of cancer of that organ would not be more likely to arrest or cure the disease, than would a similar plan of operating be likely to effect a cure in cancer of the breast. It was a well-known fact that even when the entire mamma, with all the diseased tissue, was removed, together with any neighboring involved gland, that the disease was liable to return. In the beginning cancer is a local disease. In the cervix uteri, it is invariably so and is of traumatic origin, coming on after delivery where there is laceration. The old plan of frequent cauterization of these lacerations or erosions of the cervix produced cancer, and it was difficult to tell when the disease became of a malignant nature.

The question of the advisability of resorting to extreme measures in a given case of supposed carcinoma of the uterus, was often most difficult to determine. In the incipiency of the disease there was almost sure to be great diversity of opinion among the medical men in attendance, and as a matter of course decisive, or radically heroic measures were not likely to be adopted so long as this disagreement or divergence of views prevailed, and during the delay necessarily attending divided counsels, the disease may, unfortunately, be steadily progressing towards that point at which operative interference is unapt to give permanent relief. After it has been fully determined that the disease in question is carcinomatous it is useless to scrape or partly remove the diseased tissue with the anticipation of arresting or curing it. Epithelioma of the cervix in the early stage is no milder than epithelioma of the lip, and we know very well there is no good derived from scraping or burning the lip. Even where the whole of the diseased portion of the lip is excised, the disease returns in fifty per. cent of the cases so operated upon. Operations are less likely to be successful on the uterus than on the lip.

According to general surgical principles, the proper treatment in cancer of the uterus is to extirpate the entire organ and all surrounding diseased structure, and the safest and best way to do this is through the vagina. There is no question that the operation is difficult and attended with danger, but this can be said of other operations. It is just in the performance of these difficult operations where we see such different results in comparing the operations of the skilled with those of the unskilled operator. With Billroth or Czerney, of Heidelburg, whose operation, it may almost be designated, the mortality is no greater than in an ordinary ovariotomy, that is so far as the operation itself is concerned. Where the uterus is fixed, the disease having extended to adjacent organs or struc-

tures, the operation of electro-hysterectomy is not admissible. In cases where the extirpation of the uterus is either not deemed advisable or will not be submitted to by the patient and the disease is in the cervix; the amputation of the cervix by the conical method, so as to cut above the diseased tissue is the most proper procedure to be adopted. He had operated in the last year on several cases where the uterus was fixed, and where the cases were unfavorable for successful operation; operate don in desperation of other means to relieve suffering, even temporarily. One case, in particular, operated upon with sharp spoon some four months ago, the cervix and most of the uterus was removed, giving great relief to all the unpleasant symptoms, up to two weeks ago, when the operation with a sharp spoon was repeated, a mass of diseased matter being scooped out. Up to the healthy tissue the cavity left was enormous. The patient is now quite comfortable. The galvano-cautery or themo-cautére, Dr. Thompson did not think so convenient to use or as effectual as the sharp spoon in this class of operations. There is difficulty in the application of the thermo-cautére by reason of the hæmorrhage usual in these cases. Hæmorrhage does not interfere with the effectual use of the spoon. Another case where the patient was bleeding to death, he had operated on last fall. There had been very little suffering after the operation; the case terminated fatally a few weeks since.

Dr. Schaeffer asked Dr. Thompson if, in his last case mentioned, the uterus was fixed, and being answered by Dr. Thompson in the affirmative, remarked it was therefore not a suitable case for laparotomy. Continuing his remarks, he said he had examined many specimens microscopically, and from his observations, was of the opinion that in the operations of removing diseased growths from the cervix much of the diseased tissue must have been left untouched. He thought a minor operation might be of value in a diagnostic point of view. He believed the only effective operation was to remove the entire uterus. He would ask Dr. Thompson what plan he would suggest in simple cancer or cauliflower excrescence of the cervix uteri.

Dr. J. F. Thompson said in mild cases he would advocate amputating the cervix.

Dr. Garrett said he remembered Dr. Ashford's cases. The case Dr. Thompson had spoken of was a woman 38 years old, who had borne children. The cancer was not intramural, but epithelioma of cervix. The operation was the conical operation, extending high up towards the fundus. The woman was a patient of Dr. Mary Parsons, and remained in good health over 5 years after the operation. Dr. Schaeffer had examined the specimen. He was inclined to doubt that cancer of the cervix was always due to traumatic lesion, as stated by Dr. Thompson. If such were the case, why should it occur in the mamma or elsewhere without being due there also to traumatic lesion. He called to mind a case in point. A tumor the size of a hickory nut appeared in the mamma of a patient of his about eight or nine years ago; cachexia was marked. The tumor was removed, but the disease returned in five years. One year ago removed the entire gland. Disease then attacked the spinal column, a general cachectic carcinomatous condition exists, she is paralyzed and in a dying condition. No local lesion exists. In regard to removal of the uterus by the vagina, at what stage of the disease is the cervix, or the whole uterus, to be removed? If we wait until the disease has extended from the cervix to the body of the uterus, then other organs will be involved; in all probability the vagina, the rectum, the bladder, and the adjacent tissues would become infiltrated, and then the operation would be most difficult.

Dr. Thompson said men are all the time performing these operations of amputating portions of the cervix or the diseased growth; some of these operations are successful, but when the operation is successful it does not follow that the case was a cancer. Dr. Ashford's case was not believed to be malignant only suspicious; most of these cases are non-malignant. No one extirpates the whole uterus for cauliflower excrescence of the cervix. When nodules are felt on one side of the os, or cervix, then the case may be set down as carcinomatous, and will recur, no matter if little or much of the cervix be removed. Emmet says this in regard to his own cases, that is, that when there are nodules and ulcerations the operation will not be a success.

Dr. Schaeffer agrees entirely with Dr. Thompson, cases set down as carcinoma

are most apt to be hypertrophy of cervix. Carefulness in diagnosis will remove many cases from the list that heretofore were charged to cancer or credited as a case of cancer cured. He is now a firm believer in the local and traumatic origin of cancer but formerly considered the disease constitutional.

Dr. Garnett asked Dr. Schaeffer if he did not think the local disease ever occurred without a traumatic lesion.

Dr. Schaeffer said in some constitutions it might.

Dr. Garnett asked Dr. Schaeffer how he accounted for cancer in the pancreas, stomach, liver, spleen, &c.

Dr. Schaeffer said he had seen twelve cases of cancer of pancreas, and in every case it was secondary to cancer in some other portion of the body.

Dr. Taylor asked Dr. Schaeffer how he reconciled heredity with the local and traumatic doctrine.

Dr. Schaeffer said he would then fall back upon the bacillus theory, a man may be born with cancerous proclivity, he may be swarming with the cancer bacillus, and a blow may localize and develop the disease dormant in the system.

Dr. W. W. Johnston: Dr. Schaeffer has, in his explanation, adopted the constitutional theory *in toto*, not the traumatic. He (Dr. Johnston) considered extirpation of the uterus one of the most important operations in surgery. It takes a place by the side of extirpation of the mamma. The operation, to insure success, should be performed early, and analogy would force us to the removal of the whole organ. It is not well to depend upon the microscope to make a diagnosis, the finger is the best guide. It would be better, in a very doubtful case, to remove the uterus and run the risk of doing so unnecessarily, than to risk leaving a carcinomatous disease to progress until it was too late to operate with a fair prospect of a successful issue. For the same reason he would not waste time in resorting to palliative measures, from which there was no reasonable hope or expectation of deriving permanent benefit, and from the irritation of which there was great danger of increasing cell proliferation, and thereby bringing about that very condition that would negative all operation that had for its object a radical cure. In regard to cancer of the breast, he would say that in those cases which had fallen under his observation, extirpation had not proved successful in removing the disease; it had always returned in one or two years. In a case now on hand, produced by the kick of a child, the whole mammary gland was removed, together with the axillary and other involved glands, and now there is disease of the kidneys; albumen and casts in the urine, pains in the head, leading to coma, which raises a question as to probability of cancer of kidneys. Another case, cancer unsuspected. The lady came from the West, and was under treatment for neurasthenia; there was great craving for food. Massage had been tried, together with rest; and, unfortunately, stimulants. The full history of the case was written out by the physicians who had been in attendance. First the stimulants were reduced, then continued massage. Deep-seated pain during defecation led to an examination which disclosed cancer of the uterus. The rectal passage was obstructed. The case terminated fatally six or seven months after the discovery of cancer.

Dr. John B. Hamilton said: I am glad the discussion has taken this wide range, for the subject of histogenesis of carcinoma is one of the deepest interest. I am glad to hear the theory of the local origin of cancer so distinctly enunciated, for I believe that the only one that will stand all the clinical and theoretical tests.

In thus affirming belief in the local origin of cancer, I do not think it necessary to adopt the doctrine of traumatism for every case of cancer. It may be traumatic or it may be neuropathic, that is to say, it is the irritation of the part that is the starting point of cancerous growth, whether that irritation be due to direct violence, or to reflex hyperæsthesia, whether the original seat of the carcinoma be the connective tissue or simple budding from atypical cells, there is an antecedent irritation. As to the query of the President, how, if the disease be local, I account for the heredity of the disease; I answer that there are some things I am not obliged to account for. I do not account for the observed fact that the lineaments of a child's face may resemble in a marked degree those of his father; that certain organs for instance, may be formed in the parent, of defective cells, and the child as well partake of this defective organization. I do not undertake

to explain this, nor do I consider it pertinent. I am satisfied with the fact, that in the formation of carcinoma we may see the departure from the normal structure in the first infiltrated cell. As to the chemical differences between the non-malignant and the carcinomatous growths, it is doubtless true, as Dr. Thompson has said that in those cases where there is a marked projection of the diseased growth in a papillary form, the disease is not cancerous, and may be considered non-malignant, for we are aware that the epithelial proliferation—the budding—takes place *into* the parenchyma of the organ, infiltrating and crowding out of place the connective tissue fibres.

There is another point having a distinct clinical bearing, and that is that the growth which may have been non-malignant in the beginning, may take on a carcinomatous transformation. We may have for instance in the myxoma, a simple hyperplasia of the mucous glandular structure; but a slight departure from the normal type and a malignant myxoma is developed. We see in the sarcoma which may begin as a giant-celled non-malignant growth, a transformation to the spindle-celled, or the round celled, the latter the most malignant variety. The lesson to be learned by these clinical facts, is that the growth should be removed early and be thoroughly extirpated, the rule being in case of the involvement of a gland to remove the entire gland to prevent the general infection through the lymph channels. Believing in the local origin of carcinoma, I am bound to believe in its curability by extirpation. Gross, in his recent work on Mammary Tumors, has given instances where after repeated recurrences of the growth in a female breast, which was each time removed, the patient had survived; as much as twelve years having elapsed in one case from the primary operation. In reply to a question as to the "dyscrasia," Dr. Hamilton said, that he of course did not wish to be understood as denying that when a cancer had progressed to a general infection through the lymph channels, that the disease was not then constitutional, but that that condition was analogous to that of any other poison, it was not the primary lesion, which was after all the point at issue.

Dr. Taber Johnson said: Referring to the mortality attending operations for the removal of cancer from other portions of the body, that in Billroth's Clinic, the mortality from mammary cancers was 20 per cent.; from lingual cancer, 43 per cent.; from rectal cancer, 53 per cent. In Rose's Clinic the mortality from mammary cancer was 26.3 per cent.; rectal cancer, 53 per cent.; from lingual cancer, 11 per cent.; while of the total number of 256 cases of vaginal hysterectomy, collected by Dr. Mundé, for cancer of the uterus the percentage of mortality was 24.6 per cent.

Dr. Johnson referred to the operations of Marion Sims and Van de Walker in which the cancerous cervix and a conical Λ shaped portion of the body of the uterus was removed by the scissors and sharp curette and the cavity subsequently packed with chloride of zinc cotton. In these cases, after a number of days the cotton is removed and a slough comes away, leaving presumably only healthy tissue behind.

This process is tedious and not devoid of danger, inasmuch as the caustic may destroy more tissue than is intended, requires a second operation for its removal, and secondary hæmorrhage is not am infrequent occurrence. Baker, of Boston performs the same operation in about the same way; but, instead of applying the zinc chloride and the cotton packing, thoroughly cauterizes the parts with the thermo-cautery and applys no cotton packing to prevent hæmorrhage, or dressing of any kind. It seems a more thorough, cleaner and safer operation.

Baker recently reported that at the end of five years five of his cases were alive and doing well, while one had recently died of a return of the disease.

Dr. Thompson said he recommended just such treatment as Dr. J. T. Johnson had just advocated in the class of cases he had mentioned. In speaking of hysterectomy, he referred to the case where the uterus was movable, and where consequently the operation was entirely practicable; in such cases it was not advisable to resort in the first instance to the minor operation, if it was in contemplation to resort to the entire removal at any subsequent time; for the amputation of the cervix would render it almost impossible to remove the uterus through the vagina. As to hereditary and constitutional diseases, he considered them entirely different. He has now a case on which he has operated three times for mammary cancer, twice on the right and once

on the left side, and will continue to operate as often as the disease reappears, if allowed to do so by the patient; and, although the disease in this case is both hereditary and constitutional, he expects by extirpation of the local disease as it appears, to entirely eradicate it from the system. In the majority of cases the second operation does the work, for then there is not so much likelihood of part of the diseased tissue being left. The difficulty about secondary operations is that the woman becomes discouraged, thinks it of no use, and gives the matter up, and consequently dies, or puts off the operation so long that the system is broken down, and the constitution too much shattered to stand the shock of the operation.

Dr. W. W. Johnston would suggest that the primary disease always occurs at a point of irritation. Organs subject to alternations, as observed by Dr. King are most obnoxious to the disease. If cancer were hereditary it would be just as likely to occur in one place as another. A minor operation, partially removing the diseased organ or diseased tissue favors the general diffusion of the disease throughout the body, and on that account is to be deprecated, when the whole of the disease can be removed by a more thorough and radical operation.

Dr. Garnett to Dr.W.W. Johnston. The doctor says cancer attacks the point of irritation or organs subject to alternations, independent of constitutional predisposition. How then account for its attacking bone. And, again, take six people, one of whom has hereditary predisposition to cancer; will not cancer attack that one in preference to the other five, on the occurrence of traumatic injury, and if such be the case, does it not show that hereditary predisposition counts as something in the causation of the primary local manifestation? He did not exactly understand Dr. Thompson's remarks in regard to hereditary and constitutional predisposition to disease.

Dr. Thompson answered that there was no reason why an hereditary disease could not be local. A constitutional condition predisposes to a local cause. Heredity can give rise to local predisposition to cell life; up to the development of a cancer cell there is no cancer in the body.

Dr. Garnett said he did not wish it to be understood that he was agreeing against surgical interference in the disease under discussion; but differed as to the stage of the disease at which the operation should be performed; recognizes local development of constitutional disease, and does not say the removal of the local may not affect the constitutional; contends that constitutional predisposition is the cause of cancer, if this were not so, it is strange that Dr. Thompson's case, just spoken of, is making so many developments of disease, she must have her system saturated with cancer.

Dr. Thompson said he supposed Dr. Garnett took one of two positions, namely, the old or the new; the old writers contended that the disease was existent in the body before it became localized in the form of cancer, whereas the late authorities contend that there is no cancer in the body until the local disease makes its appearance; then after that the system may become infected, and constitutional symptoms appear in the form of the so-called cancerous cachexia.

Dr. Garnett asked Dr. Thompson, if in inherited syphilis, a child apparently healthy at birth and remaining to all appearances healthy until six months old and then developing syphilis, he would not say that the child was syphilitic from birth?

Dr. Thompson in reply said, in his opinion the child would not be syphilitic until there was a local syphilitic lesion, whether that local lesion appeared six months or thirty years after birth.

On motion of *Dr. Acker*, further discussion of Cancer of the Uterus was postponed to the next meeting of the Society.

On motion of *Dr. W. G. Palmer*, the meeting then adjourned.

Correspondence.

ON MEDICAL EDUCATION AND PRACTICE ABROAD.

Editor Md. Medical Journal:

The following facts may be of interest to the readers of THE JOURNAL:

In Austria, Hungary, are seven institutions in which medicine is taught. This in a population of 37,703,000 is one Medical School to every 5,529,000 inhabitants. The ratio is probably even less, since the population is taken from the census of 1878, while the number of medical schools is

from the enumeration of 1882–3. At this rate there would be in the United States ten institutions capable of conferring medical degrees. In the German Empire for about 43,000,000 inhabitants, there are twenty institutions conferring the degree of Doctor of Medicine, or one to every two million inhabitants. In that proportion the United States would have twenty-five medical schools. As a matter of fact there are about ninety.

To get a German degree requires usually five years of study and hospital work although the examinations by great crowding can be compressed into four years. The examinations are severe, are both written and clinical, and after all this is done, there remains the thorough State examination to be passed before the candidate is allowed to practice.

In England four years are required, the candidates are obliged to pass examinations before certain specified qualifying bodies. No one can be examined by any teacher from any medical school in which the candidate has previously studied. No institution giving medical instruction can confer a right to practice as a rule. The few exceptions, Oxford and Cambridge Universities, etc., have very high standards. The great Examining boards in England, the Royal College of Physicians and the London University, give no instruction whatever, in medicine.

In spite of the smaller number of practitioners, the fees will average on the Continent less than in America in proportion to the expenses of living. In England they are about the same as in America.

There is no lack of physicians anywhere excepting in a few sparsely settled and poverty-stricken districts, where even the most economical practitioners cannot exist. In these cases, the government (in Germany) usually subsidises the physician for his charity visits. On the Continent, a physician, as a rule, is only called, in obstetric cases, when the situation has become desperate and operative interference is called for. European midwives are quite capable of conducting an ordinary case of labor and recognizing in time the need of instrumental aid. W. B. Platt, 165 Park Ave.

The next International Hygienic Congress will be held at Vienna in 1886.

Editorial.

Dr. Steiner's Election as Librarian of the Enoch Pratt Free Library.—The profession has been honored by the selection of Dr. Louis H. Steiner, of Frederick City, Md., as Librarian of the new Enoch Pratt Free Library of Baltimore, which has just been completed at a cost of nearly $1,000,000. Dr. Steiner has accepted the position, and will at once enter upon the task of selecting the books with a view to an opening to the public about January 1st. Dr. S. is a native of Maryland, and is now in his 58th year. He obtained his academic training at Marshall College, Mercersburg, Pa., and his medical at the University of Pennsylvania, where he graduated in 1849. He has held the chair of chemistry in several institutions, as the National Medical College, of Washington City, the College of St. James, Md, the Maryland Institute, and College of Pharmacy of this city. He has taken an active part in many societies, being connected with the American Medical Association, the Medical and Chirurgical Faculty of Maryland, the American Association for the Advancement of Science, the Philadelphia Academy of Natural Sciences, the Maryland Academy of Science, the American Public Health Association, the International Medical Congress of 1876, and the American Academy of Medicine; he was president of the last named in 1878. He has thrice represented Frederick County in the Senate of Maryland. He has contributed freely to periodical literature, and was for several years assistant editor of the *American Medical Monthly*. Dr. Steiner has a high reputation for ability and scholarship, and his varied experience well adapts him to fill the rôle to which he has been assigned. It is stated that he will, in a few days, start on a tour of inspection of all the leading public libraries of the country. The Enoch Pratt Library will contain only popular books, which will be generally read; no technical works will be purchased.

Weight as an Indication of the Character of Risks for Life Insurance.—Dr. Joel Seavern gives in the *Boston Med. & Surg. Journal*, of Oct. 23d, some facts formulated from the death tables of the Royal Arcanum (containing the records of 974 deaths) which no doubt will prove inter-

esting to medical examiners of insurance companies and beneficiary societies. He gives in tabulated form the records of 138 deaths of persons whose weight was less than 20 per cent below the standard. The standard weight being estimated in relation to the height of the individual. He shows that a weight of 15 per cent. below the normal standard carries with it a liability to constitutional disease, especially to chronic diseases of the lungs, even in cases where the family history is apparently free from such diseases. On the other hand, he finds that persons weighing over the standard weight may be considered as better risks, as the death records in these cases point out an increased ratio of mortality from acute diseases, at the same time showing that the number of deaths from cardiac and cerebral diseases is much smaller than would be naturally anticipated. In concluding, he asserts that with regard to "light weights" the usual variation of 20 per cent., which is assumed to be within safe limits, is not safe; and if young men are accepted whose weight is 15 per cent. below the standard, it is approaching dangerous ground, and inviting, as it were, deaths from phthisis, etc. With the "heavy weights" the case is different. Provided that we see that heart and kidneys are healthy and that the family history does not point to cerebral disease, a margin of 25 per cent. above the standard is not dangerous in men who have not injured, or are not injuring themselves with alcohol.

The Rabbeth Memorial.—Some few weeks ago Dr. Samuel Rabbeth, a highly esteemed and rising young physician of London, lost his life with diphtheria contracted from a tracheotomy tube in the throat of a child ill with that disease. The circumstances surrounding the case, the heroism and character of the deceased at once called forth many expressions of profound admiration and deep regret from the English profession and public. It was considered a noble impulse which actuated this talented young physician to risk his life to save the life of a helpless patient. His death, therefore, was one which was calculated to arouse a deep emotion and sympathy in many breasts. We are not surprised to observe that a movement is on foot to raise a memorial fund to commemorate this act of unselfish professional conduct and to perpetuate the memory of a death induced through a high conception of professional duty. The example of Dr. Rabbeth is not unique in the history of professional adventure. Numerous deaths have been placed upon record in medical practice induced by this same disregard of self in the attempt to rescue the lives of others. The tracheotomy tube seems to be an ill-fated contrivance in encouraging physicians to jeopardize life to save life. The physician who employs suction with his own mouth to remove an obstruction from a tracheotomy tube in a case of diphtheria, must be aware of the great danger to which he is exposing himself by this act. He must also know that the risk he assumes is out of all proportion to the benefit he is likely to secure by his recklessness. Acts of courage and heroism are ever worthy of encouragement when performed in obedience to duty. But is it not time that some other method of employing suction to clear tracheotomy tubes was devised? Do not deaths resulting from this cause indicate a recklessness and disregard of life that should be discouraged? In France, where many deaths hav etaken place among physicians from this cause, tablets have been erected in hospitals to commemorate these sacrifices. In other words a premium has been put upon this kind of professional service, and public sentiment seems to say that a physician fails to do his duty unless he risks his own life for that of his patient. The celebrated legal case of Messrs. Bower & Keates is an illustration of the effect of this method of dealing with tracheotomy cases. It will be remembered that these physicians instructed the father of a child ill with diphtheria to keep the tube open by suction. In a civil suit instituted by the father of this child, the point was made that these practitioners failed to do their duty in not informing this parent of the danger he ran in sucking the tube. It was implied by the prosecution that this duty was professional not parental

Whilst the profession of medicine should encourage every noble and humane act in saving life, it should not go wrong in its sympathies and place premiums upon recklessness and a false standard of professional duty.

A Monument to Prof. Cohnheim.—A few weeks back the death of Prof. Cohnheim was lamented throughout the medical

world by all who were acquainted with his great scientific attainments and original contributions to pathological knowledge. Though comparatively young at the time of his death, few men had been so greatly endeared to a large number of friends and pupils as this widely known pathologist. Prof. Cohnheim is remembered not only on account of his great scientific attainments, but he was noted for a charm of manner and a warm-hearted nature which drew his pupils to him and stimulated in them much of his own enthusiasm for experimental pathology. It is related of him that he so facinated those in contact with him in the studies which deeply engaged his investigations, that the dry subject of pathological research was invested with a living and vigorous interest. The influence and character of such an investigator and teacher should not be forgotten. We are therefore pleased to announce that a movement is on foot in Germany to erect a suitable monument over his grave with a fund contributed by his friends and pupils now scattered throughout Europe and America. Those wishing to contribute to this fund are requested to remit to Prof. His, of Leipzig.

Book Notices and Reviews.

The Lock-Jaw of Infants (*Trismus Nascentium*), *or Nine-day Fits, Crying Spasms, etc. Its History, Cause, Prevention and Cure.* By J. F. Hartigan, M.D., Washington, D. C., Member of the American Medical Association, etc. Bermingham & Co. New York. pp. 123.

In this monograph, dedicated to the memory of Dr. J. Marion Sims, as the discoverer of the true pathology of trismus nascentium, the author argues for the theory brought forward by Dr. Sims in 1846, and further elaborated by him in 1848. After reviewing minutely the various theories before the profession regarding the etiology of the disease, the author reports a large number of cases, both from his own observation and those of other physicians, as supporting and indeed proving the correctness of Dr. Sims' theory, that the disease is of centric origin, depending upon mechanical pressure exerted upon the medulla oblongata by an inward displacement of the bones forming the lambdoidal suture, *i. e.* the occipital or the parietals. He shows that in many instances *position* alone is all that is required to relieve the symptoms, and to cure the disease, provided the treatment be instituted at a reasonable time after the commencement of the attack. As a result of many post-mortem examinations, he records a congestion of the spinal cord and the base of the brain, and the enveloping membranes, with the arachnoid cavity more or less filled with coagula, as the constant lesion of the disease.

The work is comprehensive, shows a thorough and honest investigation of the subject, and well deserves a careful perusal.

BOOKS AND PAMPHLETS RECIEVED.

A Practical Treatise on the Diseases of the Ear, including a sketch of Aural Anatomy and Physiology. By D. B. St. John Roosa, M.D., L.L.D., Prof. of Diseases of the Eye and Ear in New York Post-Graduate Medical School, etc. Sixth Edition. Revised and enlarged. New York: Wm. Wood & Co. pp. 702.

A Treatise on Physiology and Hygiene for Educational Institutions and General Readers. Fully illustrated. By Joseph C. Hutchinson, M.D., L.L.D., Ex-President of the New York Pathological Society, etc. New York: Clark and Maynard, 1884. pp. 319.

The Elements of Physiological Physics. An Outline of the Elementary Facts, Principles, and Methods of Physics; and their application in Physiology. By J. M'Gregor-Robertson, M.A., M.B., C. M., Muirhead Demonstrator of Physiology, and Asst. to Prof. of Physiology in the University of Glascow. Illustrated with 219 Engravings on Wood. Philadelphia: Henry C. Lea's Son & Co., 1884. pp. 528.

Obstetric Aphorisms for the Use of Students commencing Midwifery Practice. By Joseph Griffith Swayne, M.D., Consulting Physician Accoucheur to the Bristol General Hospital, and Lecturer on Obstetric Medicine at the Bristol Medical School. Eighth Edition. Philadelphia: P. Blackiston, Son & Co., 1884. pp. 148.

There are fifteen new students the present session at the Woman's Medical College of London.

Miscellany.

Dysmenorrhœa Treated by Rapid Dilatation.—In a Clinical Lecture by Dr. Wm. Goodell (*Med. and Surg. Reporter*, Nov. 8th, 1884), we learn that he has performed this operation 168 times. It is *the* operation in mechanical dysmenorrhœa (the most common form, perhaps, and due generally to anteflexion of the uterus with stenosis of the cervical canal). The tendency of this is to continue and increase, owing to the repeated distension of the uterus. Dilatation is often of great benefit also in the nervous and hysterical form. Dr. G. has never had any more serious symptoms than local peritonitis, (in one case only at all severe) and in two cases laceration of the cervix, to result from the operation; he keeps the patient in until the soreness is gone (usually 48 hours). He uses two dilators, of the Ellinger pattern. Ether is required. There is no comparison as to safety between this and the cutting operation, which has been followed by many deaths, besides being less successful than the other. Improvement after dilatation is usually very marked, though there may be pain with one or two periods. To relieve pain he introduces one or two suppositories of one grain of opium each. For soreness, a poultice is applied, or ice if the temperature rise above 102°, and the patient is kept in bed for 48 hours after the soreness has disappeared. Of Dr. G.'s operations in the vast majority there has been immense improvement, and in a large proportion a positive cure. Occasionally a second operation is required. If done for dysmenorrhœa it it is done after menstruation, if for sterility, before.

Jequirity: Its uses in Diseases of the Skin.—*Dr. John V. Shoemaker*, of Philadelphia, in concluding a paper on the above subject read before the State Medical Society of Pennsylvania, says: In summing up the results of the treatment of diseases of the skin with jequirity, I am lead to pronounce it a most powerful agent, applicable to all cases of unhealthy, ulcerating, and granulating conditions, upon which it certainly exercises a destructive tendency, followed by a constructive change, and, forming under the protective covers of the exudation, it causes a rapid development of healthy tissue. Though under proper conditions and careful supervision a remedy of the greatest service, it should be applied with proper caution, as it may give rise sometimes to alarming symptoms, erysipelatous inflammations, and if used on weak and irritable patients to great constitutional disturbance. These symptoms, however, will speedily subside with proper attention, and on the drying of the crusts.

That jequirity has a still greater field than simply that of ophthalmic practice will readily appear as a deduction from my experience. Though the *modus operandi* of its action as stated by me may be modified in the course of time, its curative results in the class of cases to which I have referred are indisputable, and will be more fully developed as it finds more general application and introduction.

Intermittent Pulse.—*Dr. B. W. Richardson*, writing on this subject (*Asclepiad*), says: If it occur in infancy it is an important indication of the existence of serious nervous derangement. Occurring in young adults it has the same significance indicating a commencing failure of power. In five cases he has known it to be the first physical indication of derangement of mind, in which suicide was attempted. In persons advanced in life, and in persons prematurely old, intermittency is often the precursor of symptoms of nervous failure. Persons, in whom there is permanent intermittent action of the pulse, pass through all acute diseases with less chance of recovery than others of similar age and like constitution, who have no such failure. The author also states that he has often noticed the hereditary character of the phenomenon. With references to treatment there is no known specific method. Excitement should be avoided, and in cases where there are symptoms of cerebral congestion depletive measures are proper. Nothing relieves the intermittent action of the heart so rapidly as alcohol judiciously administered, and *vice versa*. All alcoholic fluids as beverages should be avoided; but if demanded, half ounce of pure alcohol in warm water is often most effective.

The Medical and Surgical Societies belonging to the Paris hospitals have decided on no occasion to admit women to compete for positions in the hospital service.

Medical Items.

Twenty out of one hundred and thirty-nine medical practitioners engaged in attending cholera patients at Naples, under the White Cross Society, died.

W. Alder Smith, M.B., F.R.C.S., believes a solution of seven grains of chrysophanic acid in an ounce of chloroform to be the most efficient application for recent ringworm.

Dr. McEwen operated at the Glasgow Royal Infirmary a few days ago for malignant tumor of the pylorus. The patient, a woman, sank from the shock some hours afterwards.

Dr. Kronecker, Professor Extraordinary at the Berlin University, has been appointed Professor of Physiology in the University of Bern, vice Prof. Grützner, who goes to Tübingen.

The new Presbyterian Eye, Ear and Throat hospital of Baltimore, was opened on the 11th and 12th instants for the inspection of the public before opening the wards for the reception of patients.

A death from chloroform is reported in the practice of A. K. Steele, of Chicago. It was sudden and due to cardiac paralysis, the heart fibres being infiltrated with fat, the wall thin and pale, and the coronory arteries and aorta atheromatous.

A new dental Institute, with Dr. F. Busch as Director, was opened in Berlin, Oct. 15th. The want of such a dental institution has long been felt there, a large number of German dental students having been obliged to seek instruction abroad.

A death during the inhalation of methylene occurred at the South Devon and East Cornwall Hospital, Plymouth, England, recently, during an operation for the removal of some fragments of stone which had entered the arm in blasting. Death was sudden and was ascribed to paralysis of the heart.

Pettenkofer upholds his "localist" views of cholera, and offers to swallow the comma bacilli cultivated by Koch himself, "provided there is no temporal or local disposition for cholera (that is that it is not prevailing.)" He even declares his willingness to acquire catarrh of the stomach or intestine previous to the experiment.

Dr. Schweninger, Prince Bismark's physician, recently appointed Professor of Dermatology in the University of Berlin for services rendered to the chancellor, has challenged Prof. Du Bois Reymond of the same University to fight a duel because Prof. R. returned his cards left when he called upon the Professor. The latter declined the challenge.

Dr. Koch's courses in bacteriology are now going on in Berlin at the Imperial Board of Health. Twelve medical men attend and receive instruction in the investigation of the dejecta, the cultivation of the comma bacilli, and in the preventive measures to be adopted in cases of outbreak of cholera. Successive courses will be given, each lasting a month.

At the opening of the Societé de Chirurgie, Paris, Oct. 1st, M. Terillon reported thirty-three cases of ovariotomy, twenty-nine of which recovered, and four died. Twenty-seven continued in good health; of the remaining two, one died shortly after operation from diffused cancer, the other had a tumor in process of formation, but her general health did not suffer.

At the last meeting of the New York County Medical Society Dr. Austin Flint read a paper on "The Parasitic Theory of the Epidemic Cholera," and pleaded for a greater amount of original work in the study of the parasitic origin of diseases by American physicians, suggesting, if not prophesying that in this field the honor of making permanent and important discoveries was to be obtained.—*Phila. Med. Times.*

A tablet will be placed in the capitol in Rome, commemorating King Humbert's visit to cholera-stricken Naples, and containing the following (*Lancet*): "The Roman Senate and People to record to posterity that King Humbert I. in September, of 1884, hastened to Naples in her affliction from epidemic cholera, bringing into her hospitals (hovels) courage, consolation, relief, and until the scourge abated remained there amid the blessings of all Italy trembling for him. Rome, rejoicing to salute his safe return, proud of her king, interpreting the universal gratitude, placed this tablet."

Original Articles.

NEURALGIA, ITS CAUSE AND CURE

BY ROBERT REYBURN, M.D., WASHINGTON, D. C.

It must be remembered that in speaking of the cause of neuralgia, in the present paper, I refer more especially to the chronic form, and not that dependent upon acute or local causes.

Probably every physician in active practice, knows by a fore-knowledge, born of repeated experiences, that when the atmospheric conditions are favorable to its development, there exists a class of patients who, he feels certain, even before he visits them, will be suffering from some one or the other protean forms of neuralgia.

In other words, a glance at the barometer, showing, it may be, the fall of an inch in the mercurial column, will enable the doctor to prophesy to himself, the chronic invalids among his patients, who will, when he makes his daily round of visits, complain either of exacerbations of the old pains or of new developments of neuralgia.

Now is this condition of things, so constantly occurring, merely a coincidence, or is it dependent upon a cosmical or universal cause that can be traced by its effects?

I do not think that this can be a coincidence, for it recurs entirely too constantly to be susceptible of such an explanation.

It will be my endeavor to attempt to give the reason why neuralgia is coincident with the fall in the mercurial column, or what is the same thing, exists with the diminution of the pressure of the atmosphere.

Dr. S. Weir Mitchell, in his very instructive and valuable article published in *The American Journal of the Medical Sciences*, for April, 1877, p. 305, has shown that when the atmospheric pressure is lessening and the mercury is falling, the neuralgia occurs during the fall of the mercurial colulmn and before it is complete.

He also states that every storm as it sweeps across the continent, moves upon the storm centre of greatest depression of the barometer like a bead upon a string.

The rain precedes this greatest depression of the barometer, being in advance of it 350 to 600 miles.

Before and around the rain storm lies the neuralgic margin, or border of the storm, and which precedes the rain storm by about 150 miles.

The facts above stated can be easily demonstrated by the records of the Signal Office, and assuming their correctness, I believe that the following is a simple explanation of the connection between these phenomena:

Ganot's Physics, Am. edition, p. 107, says that the superficial extent of the surface of the body of a man of medium size is about 16 square feet, the total amount of atmospheric pressure on the surface of the body is consequently about 35,000 lbs. (34,560).

Taking the average height of the mercurial column as 30 inches, a fall of only one inch, shows that 1-30 of the pressure of the atmosphere is for the time being removed from the surface of the body or more than half a ton, and a fall of less than two inches will remove a ton of pressure from the surface of the body.

The heart, it must be remembered, aided by the contractions of the blood vessels, is pumping the blood through the system with the same, if not greater, force than when the air is in its densest condition.

The necessary result of this condition of things is that a much greater pressure is exerted upon the blood vessels, and more especially upon the smaller arterioles and capillaries, and which, from the sparsity and in the case of the capillaries, the entire absence of muscular or elastic fibres, in their walls, are ill-adapted to withstand such increased pressure from behind.

If the strength of the coats of the smaller blood-vessels or their contractile power be diminished by the malnutrition of anæmia, or in fact, by any condition of the body which deteriorates the general health, the vessels passively yield to a certain extent and become overfilled with blood, and we have then the condition known as passive hyperæmia.

But the mischief done does not end with the hyperæmia; these engorged blood-vessels are accompanied and surrounded by an enormous development of nerve filaments, which are pressed upon, and being functionally disturbed by this pressure, we have as a necessary sequence, the development of neuralgic pain in the part.

Certain conditions, which may now be mentioned, act powerfully in aiding the development of neuralgia, as, for instance, cold, especially when combined with moisture. The reason, no doubt, why cold and

moisture combined act so much more promptly in the production of neuralgia than the same amount of exposure to dry air, is that moisture greatly increases the conducting power of the air to convey the animal heat away from the body.

In Arctic regions, for instance, the human body will resist even lower temperatures than that at which mercury freezes (40° below zero), provided the air is perfectly dry and still, but should the air become a better conductor, either by becoming moist or by the wind beginning to blow, and thus conveying the heat of the body away faster than it can be be kept up by the vital processes, death will ensue from even a short exposure.

We find also, other things being equal, that neuralgia chiefly affects those parts of the body that are abundantly supplied with a vascular net-work, and which are unprotected by clothing, thus exposing them to changes of temperature.

This explains why so many cases of neuralgia are found existing upon the parts of the face supplied by the fifth or tri-facial nerve.

The obscure pains so commonly observed before storms, in old wounds, inflamed joints, and other organs, which are commonly referred to rheumatism, are easily explicable by this theory of increased vascular congestion, the vessels in chronically inflamed parts are always enlarged, and the diminished atmospheric pressure upon the outer surface allows the vessels to become more dilated, and hence pain is produced.

TREATMENT.

The remedies that are generally used in neuralgia, and to which we all naturally turn, are opium and morphia..

Now these remedies resemble what Sir Walter Scott said of the pursuit of literature for a livelihood; they make an excellent staff, but ought not to be used as crutches, In fact, the habitual and continuous use of morphia and opium as it is so often given to chronic invalids in neuralgia is a most dangerous and reprehensible practice, and is ruinous to the physical and moral well-being of the patient.

The temptation is very strong to every physician to relieve his cases, as he can, rapidly and certainly, by the use of his hypodermic syringe or giving internally his dose of morphia, but he ought to remember that this is a potent remedy, and one which injures the tone of the nervous system if too frequently given.

Morphia and opium are then, from this standpoint, not curative so much as palliative; they no doubt act by benumbing the sensory filaments of the nerves, by inducing sleep, thus allowing the nervous force time to be regenerated.

The power over involuntary muscular fibre, which opium and its alkaloids exert over the circular muscular fibres of the iris, and probably over other parts of the body, may be an important factor in its use in the cure of neuralgia. Next in importance in the treatment of neuralgia to opium, naturally comes the group of anæsthetics, which includes the alcoholic beverages with sulphuric ether, chloroform, hydrate of chloral and paraldehyde. Alcohol is a potent and powerful remedy in neuralgia; to be efficient it must be given in large doses, and is then a true anæsthetic, benumbing and destroying the pain, thus inducing sleep.

While acknowledging the potency of alcohol, ether, chloroform and hydrate of chloral, etc., in neuralgia yet their use when continued for any length of time is accompanied by so many grave dangers as to greatly limit their usefulness.

Quinine is not in any appreciable degree an anodyne, and yet no remedy is given more frequently or with greater benefit than this powerful drug in cases of neuralgia.

How does quinine relieve in curing neuralgia? I believe it acts in two ways. First, and chiefly by its powerful tonic influence upon the vaso-motor system of nerves, controlling the circulation in the blood vessels, thus enabling them to resist the *vis a tergo* which tends to over-fill them, and causes them to press unduly upon the sensitive filaments of the nerves, in contact with them. This tonic power, as has been noticed by many observers, does not pertain in any great degree to the other alkaloids of cinchona.

This may explain the fact that while these alkaloids are nearly as efficient as quinine in curing intermittents, yet they fail almost entirely in curing neuralgia. Cinchonidia especially, which is a good anti-periodic (five grains being equal in my experience to about three of quinine), has, in large doses, a very debilitating action upon the circulation.

A large number of experiments in the exhibition of cinchonidia, both given to patients and myself, have convinced me fully of this fact.

In August, 1876, I had a striking experimental illustration of this in my own case. During an attack of intermittent fever of tertian type. I took within six (6) hours about fifty (50) grains of cinchonidia sulphate in divided doses, and it produced such a depressing effect upon the circulation in the blood-vessels as to considerably alarm me. The pulse became feeble and sometimes intermittent, and I was compelled, for twenty-four (24) hours, to retain the recumbent position, as any effort to assume an erect position brought on an attack of syncope. Sleep was impossible, the moment I closed my eyes I saw, projected upon the walls of the room, all the pictures of scenes I ever had seen, read or dreamt of during my previous life. These symptoms gradually passed off as the system came out from under the influence of the drug.

The potent influence that quinine exerts in controlling all diseases assuming a periodical type is, of course, the other way in which quinine is useful in neuralgia, and it is in that class of cases of neuralgia, especially, that quinine produces such brilliant and happy results.

The next group of remedies generally found useful in neuralgia, are those which act by diminishing the force of the circulation, either through the nervous system, as bromide of potassium and veratum, or by their direct sedative effect upon the heart and blood-vessels, as aconite and gelsemium.

But the objection may here be fairly made to the theory here advocated, what evidence have you to offer that the remedies you speak of do act upon the heart and blood-vessels in the way you assert?

Prof. Curci (*La Sperimentale Italia Medica Jour. de Med.*, and translated in *Journal American Medical Association*, Sept. 6th, 1884, p. 265) gives an interesting series of experiments bearing upon this point. His words are as follows: "The craniums of the animals being trephined and the brain exposed, a canula of the same diameter, and open at the two extremities, is introduced into the perforation. The extremity is connected with a tube, which is in turn connected with a manometer of water. The whole of the apparatus must be hermetically closed and filled with fluid, the manometer with colored water, the rest, and especially the canula, with oil. The advantage of the oil is that, while it bathes directly the surface of the brain, it is not absorbed, and consequently does not diminish in quantity, which eliminates a chance for error."

It is necessary to bear in mind the fact that the efforts of the animal will, of themselves, influence the level of the fluid and, with patience, wait until the animal becomes calm before beginning the experiments, as calmatives cannot be given. Chloroform, ether, hydrate of chloral and paraldehyde were found to diminish sensibly the amount of blood sent to the brain, thus causing, for the time, anæmia. Morphia produced an augmentation of cerebral volume and vascular tension, and is consequently a hyperæmic. Quinine had more of a tendency to produce anæmia than hyperæmia. It counteracts the hyperæmic action of morphia.

My view, therefore, of chronic neuralgia is that it is due to a purely physical cause, viz.: increased blood pressure, and that all the remedies which relieve neuralgia act either as the anodynes do by benumbing the sensory filaments of the nerve or by diminishing the force of the circulation, or by aiding the blood-vessels to resist the pressure upon them. The pains of old wounds, of chronically inflamed joints, of the stumps left after amputations are all susceptible of a similar explanation.

There is one remedy not yet mentioned, that I have given on theoretical grounds with excellent results, and that is ergot in full doses. This is especially useful in the variety of chronic neuralgia occurring in over-fed females, in the higher walks of life, who take little or no exercise. This often takes place during or after the menopause. These people are often fat, yet flabby, indolent, prone to dwell upon their ailments, and it requires all the tact and skill that the physician possesses to manage their cases successfully. Enforced exercise and a diminished supply of food, with the use of ergot in doses of a fluid drachm three times a day, will be found very efficient. Where the above treatment fails, I have found drastic purgatives, and the abstraction of blood by leeches or cups, to be a most admirable method of treatment.

These patients are not suffering from

anæmia. They are more properly suffering from an over supply of nutritious materials in the blood, and need really a less amount of nutriment and a reduction in the volume of the blood. Let us think for a moment, what must occur to a woman at and after the menopause. For twenty-five or thirty years a periodical flow of blood has taken place, which has now ceased; the supply of nutriment and waste of the body in other respects, perhaps, continue about the same, more blood is formed than the organs of the body need, or can assimilate, and hence we may have chronic neuralgia as one of the evils that may develop from the increased blood pressure.

But this article would be, indeed, incomplete if attention was not called to the true curative treatment of chronic neuralgia, which must, to a great extent, be carried out after the paroxysm of pain has ceased.

The treatment dwelt upon in the early part of this article is only directed to the removal of the prominent symptom, which is the pain. The true *curative* treatment of neuralgia is to improve the general nutrition of the patient. It is scarcely necessary, in speaking to medical men, to dwell upon the value in such cases of iron, cod liver oil, and an abundant supply of easily digested fatty food. The treatment proper of chronic neuralgia is, in fact, the placing of the patient under proper hygienic conditions. I do not believe we have done our duty to our patients, unless we not only prescribe for the attack of pain, but also endeavor to remove the causes which induce it.

In directing the administration of nourishing food, of exercise in the open air, of plenty of sleep, we are doing our work as physicians just as effectually as if we gave all the drugs of the pharmacopœia.

1321 F St., N. W.

THE TREATMENT OF DIPHTHERIA WITH MERCURIC CHLORIDE.

BY H. D. FRY, M.D., OF WASHINGTON, D. C.

Read Before the Medical Society, District of Columbia.

I will not go into the etiology of diphtheria, nor will I theorize as to the *modus operandi* of the medicine. The value of any medicine in the treatment of diphtheria must rest its claims upon the effect of extended trials made by different observers. I have scarcely more than commenced in my experience with it, and am induced to bring up the question that I may be benefitted by the opinions of others.

I began by employing a combination of bichloride of mercury and tincture of the chloride of iron, but was forced to discontinue it on account of the gastric irritation which it appeared to cause. Giving it in solution with the elixir pepsine and bismuth, and in a small quantity of glycerine, I have not had any such trouble. It is taken readily—neither nauseates nor does it irritate the bowels.

The cases in which I have had opportunities to make use of this treatment have been, as a rule, of a mild class, and no claims as to the value of bichloride of mercury can be placed upon these, because such cases nearly always recover under any treatment. Take, for instance, this case:

Mary B., æt. seven years, complained of feeling chilly on the evening of Monday, October 14, 1884, and was feverish during that night. I saw her at noon the next day and found her right tonsil covered with membrane and a small patch on the left side. There was no external swelling. Her pulse was 140 and weak, and temperature 100. One-eighteenth of a grain of bichloride of mercury was given every three hours. The next day her pulse was 104 and temperature 98°. The membrane came off in a few days. I mention this case to call attention to the early subsidence of fever. Although high fever does not usually accompany diphtheria, it is exceptional to find the temperature down to normal within thirty-six hours from the invasion of the disease.

Another objection can be made, besides the one I have stated, to bringing forward such mild cases of the disease in support of the curative effect of any remedy, and that is the question of diagnosis. Nearly all of the statistics of the mortality of diphtheria are unreliable on account of the close resemblance of follicular tonsillitis to the disease, causing it to be often called diphtheria. And the profession is somewhat to blame for further complicating the matter in the recognition of a "diphtheritic sore throat."

Some use the term to designate doubtful cases, and others apply it to cases of sore throat which occur in those exposed to the

infection of the disease, but who do not present any pseudo-membranous exudation. Of such nature was the series of cases that followed each other in the family of the case just reported. Four children were taken within a few days of each other with pharyngitis and follicular tonsillitis, accompanied by considerable constitutional disturbance. That the *original case* was diphtheria is proven by the subsequent occurrence of pharyngeal paralysis and by an intermittent, weak pulse lasting throughout the convalescence.

I have had occasion, as yet, to employ the bichloride in only one case of the serious form of the disease.

R., female, white, aged five years, was taken sick Oct. 9th, 1884. Pulse 140, and very weak, temp. 102°. There were a dark, mottled rash of scarlet fever over the child's shoulders and back, and considerale pharyngitis. I ordered stimulants, and directed them to give a warm mustard bath; to grease the child and wrap it in a blanket. When seen several hours later the condition was in no wise improved, and the directions had been implicitly carried out. The prostration appeared great in proportion to the height of fever, and other symptoms of a general character. She was given a chlorate ot potash and tinct. of iron mixture, milk and whiskey.

Oct. 10th.—Pulse 170 and feeble, temp. 103.^{2}°. Condition unfavorable, and eruption still of a livid color. Glandular swelling at the angle of the jaw on the right side. The right tonsil was swelled, and partly covered by a patch of diphtheritic membrane. The medicine was changed to a solution of bichloride of mercury, one teaspoonful (containing gr. $\frac{1}{20}$) being given every three hours. Stimulants *ad libitum* Milk every two hours.

Oct. 11th.—Pulse 160, temp. 102.^{8}°. No improvement.

Oct. 12th.—Pulse 140, temp. 101.^{6}°. Throat looked better. Condition not otherwise changed, except the reduction of pulse and temp.

Oct. 13th.—Pulse 138, temp. 102°. Membrane had all disappeared. The bichloride was discontinued, one and a half grains having been taken in three days.

Oct. 14th.—Pulse 136, temp. 100.^{6}°. The adenitis was better.

Oct. 15th.—Pulse 140, temp. 100. There were recurrence of membrane on the right tonsil, and increase of the external swelling. The bichloride was again ordered.

Oct. 16th.—Pulse 126, temp. 99.^{2}°. Less external swelling: tonsil reduced in size, and only a small shrivelled piece of membrane visible. The bichloride was kept up for several days before being discontinued.

Convalescence and return of health were slow.

In this case, it is true the diphtheria was complicated by the poison of scarlet fever, and it therefore does not offer a true test of the value of the bichloride treatment in the former alone. Nevertheless, it is offered, because it was one of those desperate cases accompanying which we expect a high rate of mortality, and because, with the exception of whiskey, sole reliance was placed upon the corrosive chloride of mercury.

If you will pardon a slight digression, I will mention some not unimportant circumstances connected with this case. The family consisted of four persons, who lived in the third story of a store and dwelling house. A large front room, about 20 feet square, served the double purpose of a sleeping and a sitting-room. This was connected by a passage way, with a medium-sized room in the rear, used by the father (a tailor) for his work-room. Between these were two small rooms without windows or ventilation, one a kitchen and the other a water-closet.

Eight days after the development of the case of scarlet fever and diphtheria, the other child came down with scarlet fever, and four days later still the father was seized with an attack of facial erysipelas. Several nurses were sent for, but refused to put their shoulders to such a burden. The mother of the children, with the occasional assistance of some kind friend, was compelled to do the nursing of these infectious diseases, when she herself was within a few days of the expected time of her confinement.

The anxiety, the loss of rest, and the infectious influence to which she was subjected, forced her in a few days to keep her bed. She had a tonsillitis on the right side accompanied by a large, external glandular swelling, fever running from 100° to 101.^{4}°, and a pulse weak and rapid out of proportion to the local inflammation and elevation of temperature.

The inflammation ran the ordinary course of "quinsy", but even after the tonsil had

returned to its former size and the difficulty of deglutition, &c. had been relieved, the external glandular swelling increased and suppurated. The only fortunate circumstance connected with all this misfortune, was labor delayed beyond the time of calculation.

The children were now deplorably neglected, and the second one attacked died on the fourteenth day of her sickness, and twelve hours after symptoms of membranous laryngitis set in. There was an enormous swelling of the tissues of the right side of the neck, commencing like an ordinary adenitis at the angle of the jaw, and then extending around in front to a line with the centre of the chin. There was no diphtheritic membrane visible in the throat.

To return to the subject the treatment of diphtheria with mercuric chloride, I will conclude by saying that the tolerance of the mercury in such cases is, to me, indicative of its usefulness. I do not believe that I have given it in doses sufficient to obtain the best results, and in future will employ the more heroic doses advocated by some of our best authorities. If the effect is obtained by its constitutional and not local action (a point yet to be decided), may we not administer the mercuric chloride with better advantage by hypodermic injection? Large doses can be given in this way, and it is claimed that syphilitic symptoms more quickly yield to its employment.

Society Reports.

CLINICAL SOCIETY OF MARYLAND. *

STATED MEETING HELD MAY 16TH, 1884.

(*Specially Reported for the Maryland Medical Journal*).

The Society was called to order by the President, DR. J. EDWIN MICHAEL.

Drs. W. S. Smith, L. D'L. Gorgas and J. M. Hundley were favorably reported upon by the Executive Committee, and were duly elected to membership.

Dr. E. Van Hood, of St. Joseph's Hospital, was proposed for membership by Dr. Chambers.

BRIGHT'S DISEASE OF MALARIAL ORIGIN.—This formed the subject of a paper by *Dr. I. E. Atkinson*, which were the results of a clinical study of the subject by the author. The liver and spleen are not the only organs, he said, subject to the specific influence of malaria; the kidneys manifest also this influence, as shown by the occurrence of hæmaturia, hæmoglobinuria and albuminuria. Many writers have acquiesced in the belief that albuminuria, and even Bright's disease, are among the consequences of malaria. The English make little mention of this subject, because malaria is not a common affection in that country. Among American authorities who have held a similar view, are Woodward, Busey, and Da Costa. Colin, Frerichs, Bamberger, and Jaccoud maintain the negative side of the question. Some report it frequent in some localities, rare in others. Dr. Atkinson said that reference was made in his paper to extensive structural alteration of the kidneys—malarial Bright's disease.

He then quoted a series of statistics of cases coming under his observation at Bayview Hospital. In one set of cases, numbering 76, iodine had been used as a therapeutic agent; hence they could not be regarded as unobjectionable since such renal changes as were observed may have been due to the remedy. In these cases marked albuminuria was noted but 5 times, although transitory albuminuria was mentioned as occurring in some. He detailed one case in which there were decided renal changes.

He next spoke of a set of 45 cases seen last Fall, in which no iodine was given. These cases were chiefly intermittent fever. In testing for albumen picric acid was first employed, but it was found unreliable and resort was had to the heat and nitric acid test. Six of the forty-five presented albumen in the urine, in three of whom it was of transitory character. One of the six was a German, æt 29, who had been well up to the beginning of his present attack, thirteen days previously. The urine was loaded with albumen. There was anasarca in both extremities, and slight pleural effusion on the left side. Temperature normal. Under treatment by sulphate of cinchonidia the patient improved sufficiently to leave the hos-

* The publication of this report has been unavoidably delayed; but as it is an extremely interesting and important one, and, furthermore, is needed to complete the record of the proceedings of the Society, we have decided to publish it even at this late day.

pital, although dropsy and albuminuria still remained. He subsequently returned to the hospital, was again treated, and went out improved. In another case (a baker from Harford county) the attack began as a quotidian intermittent; the paroxysms then became tertian, and at last irregular. Quinine had no effect on the case. He came into the University Hospital with anasarca, debility, albuminuria, etc. He improved, left, and afterwards came to Bayview with symptoms of uræmia. He improved, left, and afterwards came a second time to the University Hospital with quotidian intermittent. He improved under cinchonidia. The large white kidney has here evidently changed into the hard contracted kidney, which is now the dominating affection. This patient has been under observation for two years.

Tubular and diffuse nephritis is the condition in by far the greater number of these cases, and this may be of transient character or more permanent, according as the congestion is temporary or protracted Fibroid kidney is a secondary result, being due to changes consequent upon the tubal nephritis.

Intermittent fever is the most common cause of these changes. Albuminuria is not so very common in remittent fever. Different epidemics vary in the frequency with which kidney trouble makes its appearance. The prognosis is favorable, but depends upon the duration of the nephritic changes.

In considering the pathology of the affection, the author referred to the tendency towards hæmaturia, the frank character of the inflammation and rarity, possibly absence of amyloid degeneration.

In any case anti-malarial treatment is useful; when tubal nephritis survives the use of cinchona preparations it should be treated in the same manner as though it were primary.

The following summary embraces the author's conclusions:

Transient albuminuria is common in malarial fevers, being due to intense visceral congestion. It may occur during the attacks alone, or may persist into the intervals.

In a certain proportion of cases, depending upon locality and type of disease, well-marked inflammation of the kidney occurs.

The usual form of inflammation is the tubal and diffuse, most intense near the glomeruli.

The contracted kidney may occur in advanced cases, but not as a primary process.

The nephritis may result from any form of malarial disease, but is most common in chronic intermittent fever.

There is a tendency in malarial nephritis towards recovery, but chronic Bright's disease may result from persistence of the malaria.

The treatment should be directed principally against the malarial element, which being removed, the nephritis will often gradually subside without further treatment; when the morbid changes are pronounced, often overcoming the malaria, treat as ordinary renal disease.

HANDLE OF MUSIC-BOX PASSING THROUGH ALIMENTARY CANAL OF A CHILD.

Dr. Teackle reported the following case: a child, æt. 2½ years, suddenly lost its breath; on recovering it, it burst out crying, and continued to cry for 1½ hours. It then vomited. On the following day it had stiff neck, sore throat, pain in swallowing, but no fever. After a week's treatment, the symptoms having subsided, the doctor ceased his professional visits. Three weeks later the nurse found the handle of a small music-box (which was here exhibited) protruding from the anus and removed it. Dr. Teackle thought it strange that this should have been retained so long without symptoms of its presence.

Dr. Winslow thought its very irregularity is what caused its retention so long.

RUDIMENTARY FINGERS AND TOES.

Dr. Friedenwald reported a case in which he had removed a rudimentary finger growing from the outside of the 2d phalanx of the little finger. There was a narrow pedicle. The child had clubbed feet also.

Dr. Harlan mentioned a case in which there were six toes on each foot and rudimentary fingers growing at right angles from the ulnar side of the hands. The latter were removed, but the toes were left intact.

Dr. C. Hampson Jones referred to a case where a mother had six toes; her male children were similarly affected, whilst the

female children were exempt. In this case the sexes alternated, rendering the phenomena more striking.

Dr. Ashby had met a case of rudimentary toes in a negro man, in which the male children inherited the deformity whilst the females escaped. The mother was normally developed.

CAST AND CASE OF RUPTURE OF RECTUS FEMORIS.

The President exhibited a plaster cast of Rupture of the Tendon of the Rectus Femoris muscle in a man æt. 19, who in attempting to take a train made a spring, and thinks his leg struck the car. Pain was immediately felt. Dr. M. saw him 6 to 7 weeks after the accident when the diagnosis was made as above. He could then walk well but not on the affected side with the same degree of vigor as with the other leg. The vasti and crureus seemed in normal condition but on attempted extension the muscles took the position shown by the cast. An operation was proposed for the restoration of the continuity of the tendon but was declined and no treatment was given.

CAST AND CASE OF SUBSPINOUS DISLOCATION OF THE HUMERUS.

The President also exhibited a second cast obtained from a young countryman, æt. 17, engaged in carrying the mail. He was thrown from his horse and fell upon his shoulder. A physician said that there was a dislocation and claimed that he had reduced it. Six weeks ago, 53 days after the accident, he came to Dr. Michael for treatment. The diagnosis was made with perfect ease, but attempts at reduction under chloroform were only partially successful. The limb was manipulated into a more normal position but perfect reduction could not be accomplished and Dr. Michael thought this impossible on account of the presence of adventitious tissue. Movement is more free, but some prominence remains posteriorly. He has resumed his work and can put his hand on the opposite shoulder. Sir Astley Cooper saw this accident only four times.

SPECIMEN OF EXCESSIVE DEFORMITY PRODUCED IN POTT'S FRACTURE.

The President also exhibited a specimen of Pott's Fracture. A German woman, æt. 25, while asleep walked out of a window producing the aforesaid fracture. The inner malleolus was broken off and the foot dislocated outwards. The astragalus and os calcis seem to be united by bony union. There is no apparent fracture of the os calcis. There was some exfoliation of bone at the lower and front part of the leg.

Dr. Latimer had seen this case half an hour after the accident. There was great laceration of the soft parts, fracture of the fibula and tibia protruding. The shape of the limb was restored and it was determined to try and save it, although Dr. Coskery advised amputation. No fracture of the the internal malleolus was then detected. Had a similar case last winter which occurred in sliding down a hill. It was necessary then to saw off a portion of the tibia, in order to effect reduction. The patient made a good recovery and is now walking about with a cane. Thought the deformity in Dr. Michael's case due to cellulitis, with sequent muscular contraction.

Dr. Chambers said the patient was under his care 6 to 7 weeks. She had had several attacks of erysipelas. He removed some bone. Referred to a case where a man fell into a cellar, breaking both malleoli. The parts could not be retained in position, cellulitis came on, the soft parts sloughed and the patient died of pyæmia. We can get a better result when the whole foot is broken up. A much worse break is better for the patient. A fracture of the malleolus alone will result in cellulitis.

Dr. Latimer was distinctly of the opinion that the cellulitis was an obstacle which could not be overcome. Would treat it by bandaging, making a full incision, putting in a drainage tube and syringing with antiseptic solutions. Many limbs would thus be saved. Felt confident there was no primary displacement of the internal malleolus in Dr. Michael's case.

Dr. Branham said no adhesions would take place and the patient could not be kept in bed always.

Dr. Tiffany said it was extremely difficult to treat fractures of the malleoli when occurring alone. When cellulitis occurs and the malleoli are attached to the tendons good results are impossible. He had reference to compound fractures.

Dr. Chambers said the patient was in bed four to five months and could not be kept longer in bed. He had opened the leg in many cases and introduced drainage tubes

in numbers, and had tried everything but when the patients get up there is always deformity.

The President thought he would have tried to save the limb also had he seen the case at the time of the accident. The patient was now sitting up with very good prospects for recovery.

EXPERIENCE WITH KAIRIN AS AN ANTIPYRETIC.

Dr. R. Winslow related his experience with Kairin. Having a case of typhoid fever in which the temperature reached 105°, he ordered 30 grains in six capsules; one capsule to be given every hour until three had been taken, then every two hours. At 10 A. M., when the treatment was instituted the temperature was 104⅘°; at 6 P. M., the temperature was 104, there was as yet no antipyretic effect; the pulse was weak. Five grains were ordered every hour. Four hourly doses were taken, (making 45 grains in all). At 10 P. M., the temperature had fallen to 99⅘°, the pulse to 105, und there was vomiting. At midnight the condition became alarming and Dr. W. was summoned in haste. The patient then had a pulse of 130, he had a chill and was almost in a state of collapse; was drenched with perspiration and was vomiting. His state was that of a person about to die of collapse. Stimulants were used, as carb. of ammonia and digitalis, and two hypodermic injections of whiskey. Next morning the temperature was 99⅘, pulse 95; pulse had regained its force and fulness. Dr. Winslow had looked up the subject and found the symptoms to be those above detailed, collapses, heart failure and vomiting. He regarded Kairine as an exceedingly valuable antipyretic, but its effects are transient and it should not be entrusted to the attendants, but should be administered only under observation and with the thermometer in the mouth. Dr. R. H. Thomas gives 10 grains every hour, when the temperature rises above 102° but his steward uses a thermometer during the administration and watches the result. In the case reported the temperature has not risen over 103⅘° and that to-day (third week). He recovered in four weeks.

The solutions of the muriate of cocaine employed in Vienna are ten to twenty per cent.

PROCEEDINGS OF THE MEDICAL SOCIETY, DISTRICT OF COLUMBIA.

STATED MEETING HELD OCTOBER 29, 1884.

(*Specially Reported for Md. Med. Journ.*).

The Society met with the President, DR. GARNETT, in the chair, DR. MCARDLE, Secretary.

Dr. J. Taber Johnson presented THE SAC OF AN OVARIAN TUMOR removed by him yesterday.

The solid and fluid contents, he said, weighed nine and a half pounds. The broad ligiment spread out over the tumor, and was at first thought by some to be omentum, by others intestine. There were several peculiar points about the tumor and he wished to call special attention to one hard spot.

The patient was a woman 61 years old. The tumor began, she thought, about four years ago, but she experienced no great trouble until a year ago. At that time she presented the appearance of a woman at full term. Less than a week ago she made up her mind to have the tumor removed, and she wanted it done quickly.

The operation was one of the simplest and easiest he had ever seen. There was no adhesion. There was so little hæmorrhage that even the hæmostatic forceps were not called into requisition. In making his incision he came across no muscular tissue, and hence concluded the recti walls were separated.

The woman is in good condition now, but the operation was performed only yesterday morning at eleven.

On motion, the specimen was referred to the Committee on Microscopy.

On motion, the discussion on cancer was closed.

Dr. King wished to call attention to a case of POISONING BY PENNYROYAL.

A few evenings ago he was called hurriedly to see a woman who had recently been married. The husband said his wife had gotten up and gone into the bath-room, and as she did not return, he went after her and found he lying on the floor unconscious. The odor of pennyroyal was very distinct, and upon questioning, the husband

said they had been using it against the mosquitos.

The bottle, in which there had been an ounce and a half, was found empty. The chamber-vessel into which she had vomited was examined and the oil was discovered floating on the top. The woman seemed moribund. Her pupils were dilated and her pulse very weak. The doctor gave several hypodermic injections of brandy, and in course of time she reacted and was able to swallow. She confessed, by nods, to taking the drug, but would not answer as to the suicidal intent or accidental manner. Later in the morning she became conscious and could speak, but her pupils remained dilated. When the doctor told her, she came near dying, she said she wished she had. Looking through the books, the doctor had found no mention of poisoning by hedeoma.

There were, however, several cases reported of poisoning by tansy. He did not even now know the antidote or the best mode of treatment for poisoning by pennyroyal.

On motion the Society adjourned.

STATED MEETING HELD NOVEMBER 12, 1884.

The Society met with the President, Dr. Garnett, in the Chair; Dr. McArdle, Secretary.

Dr. H. D. Fry read a paper on The Treatment of Diphtheria with Mercuric Chloride.

(See this Number of The Journal, page 94.)

DISCUSSION.

Dr. Taylor said that he had some time ago, treated a case of diphtheria with bichloride of mercury as a gargle. The patient was a young man about twenty years old. The diphtheritic symptoms were not very severe. The strength of the solution used was two grains to a pint of water. The young man was anxious to get well soon, and nervous in regard to his condition, and, therefore, used the gargle so freely that he used up the pint, or the amount prescribed, in about five or six hours. He lay upon his back holding the solution in his mouth, or gargling with it almost continuously. The result was that a large proportion of the bichloride must have been absorbed or swallowed, for quite violent symptoms of corrosive poisoning were soon manifested; burning pain, extending from the mouth to the stomach, was complained of; vomiting, and ultimately bloody passages from the bowels took place. The diphtheritic membrane disappeared from the throat, leaving the mucous membrane red and raw-looking. Diarrhœa and digestive derangements lasted for about two weeks, and left the patient considerably reduced.

In reply to Dr. Garnett's remarks in regard to the abuse of the remedy as related in this case, Dr. Taylor said he did not mention his case with a view of throwing discredit upon the practice of giving the mercurial chlorides in diphtheria, or to express disapproval of their employment, as he had little or no experience in that mode of treating the disease, but merely to show that so powerful a medicine should be used with great caution, otherwise the remedy might prove more troublesome in its effects than the disease for which it was given. He also wished to say that the symptoms in this case very much resembled the symptoms in a case reported by him to the Society some few years ago, where very large doses of calomel had been administered to a child, supposed to be suffering with diphtheria. The child took ten grains of calomel every hour, until over one hundred grains had been taken. The prescription was given by the late Dr. Reiter, of Pittsburg, Pa., who had become celebrated in his State for his treatment of diphtheria after this method. In regard to the germ theory, as to the origin of diphtheria, Dr. Taylor related the circumstance of an outbreak of the disease which occurred last year in Maryland, some twelve or fourteen miles from this city, where a family of six adults was attacked, and either three or four died of the disease. There had been no cases in the neighborhood for some years, and the disease did not spread from this family to others. It was difficult to account for the appearance and confinement of the disease in this family.

Dr. Lindsey being called upon by the President, said he was glad to see such a large attendance. He regretted that illness during last winter and absence from the city in the summer, had prevented his being present at the meetings of the Society. As it was so long since he had seen a case of diphtheria he would not venture any re-

marks upon the subject under discussion.

Dr. Toner asked if Dr. Fry intended to use his remedy as a germicide.

Dr. Fry replied that he had purposely refrained from discussing that part of the question.

Dr. Garnett asked if he had not understood Dr. Fry to say that he used the mercury in conjunction with iron. These drugs are incompatible. Dr. Garnett believed that the bichloride acted as a germicide, and to get its full effect we must apply it to the focus of disease and use it as a local remedy. He had been accustomed to use it locally ever since the efficacy of the drug in the treatment of diphtheria had been called to the notice of the profession. He found that his patients derived great benefit from a spray used every twenty minutes. Doubtless they swallowed some of the drug in this way, but otherwise he had not given it internally in diphtheria. Of course care should be taken not to abuse the drug by giving it in too large doses. Mercury is a specific for syphilis, and according to Keyes it increases the red glboules of the blood and acts as a tonic. If such be the case it is pre-eminently called for in the toxic condition of the blood as found in the diphtheritic patient. We should, however, never rely solely on its internal use. He scarcely thought it would be wise in Dr. Fry to cary out his determination to use the drug in still larger doses. If anything, he should decrease the dose, for large doses will be apt to make an injurious impression upon the stomach.

Dr. Patze called the attention of the Society to the fact that the chlorine preparations were always considered beneficial in diphtheria. Calomel had been used with great success. The chloride of ammonia had been praised. Chlorine water had been in common use in Germany for the treatment of this disease. We all know how extensively chlorate of potash is used.

Dr. Smith thought it must be gratifying to the older practitioners to see the profession of to-day returning to the old remedies. What they used empirically we now adopt rationally. Batonneau, who earliest called our attention to diphtheria, without making a marked distinction between it and membranous croup, treated his patients with calomel. Dr. Smith had found no benefit from local applications, and thought they did more harm than good. They were certainly a great source of worry and annoyance, and the instruments used oftentimes did harm. The child frequently will not, or cannot, open its mouth sufficiently wide. He lets the membrane disintegrate and take care of itself. Sometimes, if it becomes detached, he wipes it off with a mop.

Dr. Garnett thought it strange that children could open their mouths wide enough to permit their throats to be mopped, yet could not open them sufficiently wide to permit the use of a spray.

Dr. Smith said patients would not open their mouths, and he did not think it proper to waste their strength by insisting forcibly.

Dr. Garnett considered all mops and swabs injurious. Children rather liked the use of a spray.

Dr. Smith thought we did not give our remedies often enough. Some cases of diphtheria will get well of themselves; others, more severe, will require remedies to be administered every hour or oftener.

Dr. Garnett would be afraid to use the bichloride hypodermatically, for fear of setting up inflammation.

Dr. Toner said that Dr. Reiter, of Pittsburg, who had been so successful with calomel in the treatment of diphtheria, was a man of more than ordinary culture and education. He enjoyed some reputation as a naturalist, and had been connected with one or more medical schools. His use of mercury placed him in antagonism with the profession at Pittsburg. But by dint of perseverance its use had become extended throughout Western Pennsylvania, and many articles have appeared in the Journals from doctors of that section narrating beneficial results. Dr. Toner was of the opinion that the use of the bichloride was dictated by a belief in the germ theory. He would be afraid to use it hypodermatically on account of the danger of inflammation.

Dr. King was thinking, whilst Dr. Patze was making his remarks on chlorine, how much we depended on iodine, bromine, chlorine, and their compounds. Common salt is a popular remedy, and may not chlorine be the beneficent quality in sea air and sea salts. As to diphtheria, he did not believe that anybody has yet discovered a remedy reliably curative of the disease. Every little while somebody vaunts the specific quality of some drug. In turn we have had carbolic acid, chloral hydrate, calomel, chlorate of potassium, and now

mercuric chloride, each drug curing all the cases reported. So with pertussis; and the same was true of cholera when the disease was on the wane. Diphtheria is a dreadfully fatal disease, and we must confess to much ignorance as to its etiology, pathology and treatment.

Dr. Schaeffer said the weight of his histological study would be against local applications. The disease was not of the same character as an eruption. It was not confined to the outside, but was deep-seated. If the membrane came off, it left a scar; if torn off, it left the naturally moist tissues stuffed with germs. We would not be satisfied with mere local treatment in a case of erysipelas, or the bite of a venomous reptile. The local applications we are accustomed to use in diphtheria have a superficial effect. Nitrate of silver has, on that account, been discarded in hydrophobia, venereal sores, etc. When a medicine is absorbed, a part, at least, is carried to the diseased locality. We can only know the value of either treatment by taking two exactly similar cases and giving one local, the other internal medication.

Dr. Sothoron said five years ago, when we had an epidemic of diphtheria in this city, and when many of the cases were of a malignant character, he lost case after case, though giving the usual remedies, potash and iron. He then tried calomel, and lost more than ever. Two years ago he went back to quinine, iron and stimulants. He used listerine as a disinfectant and lime water in an atomizer. He sometimes applies tincture of iron with a soft brush. He believed, however, that every case of malignant diphtheria will die, do what you will. He related a case where the child expelled a perfect cast four inches long. It seemed to do better for a while, but finally succumbed.

Dr. Fry, in closing the debate, said he had purposely avoided any discussion of the germ theory. He knew that a great many remedies had been tried and that they had all failed in some cases. The severer forms of the disease still swell our mortality records. He did not know whether or not Dr. Lynn claimed priority of treatment with the bichloride. After his paper appeared, Prof. Wm. Pepper tried it, and at the meeting of the American Medical Association in Richmond, related the successful case of a moribund child saved by it use.

Dr. Lynn then read another paper on the same subject, in which he spoke of two stages of the disease, one terminating with the formation of the membrane, the other being its absorption into the system.

The theory of micro-organisms is still in its infancy. As to treatment, he had given in the beginning 1-48 of a grain of the bichloride, and now was giving the 1-18 of a grain. He had seen no bad effect from these doses. Dr. Garnett objects to these large doses. Dr. Lynn says we put off too long the proper treatment. A parallel might be drawn from quinine, which is considered a specific in malarial fevers. If one gave half a grain doses of quinine and failed to break up such a fever, he might denounce the drug. To test the full efficacy of bichloride in diphtheria, we should avoid local medication. In order to bring an adult under the influence of a solution equal to that of one to ten thousand, it would be necessary to give one grain to every twenty pounds of fluid, the patient's weight. This would produce the desired germicide effect. In one of his cases, where he gave one and a half grains in three days, the membrane disappeared; but upon withholding the drug, the membrane reappeared. He would not hesitate to use the bichloride hypodermatically. Dr. Shoemaker claims to have used it so a thousand times in the treatment of syphilis. He has given half grain doses every day for twenty or thirty days. The only objection he finds is the production of pain, and to obviate that he gives a previous dose of morphia. He uses a gold-plated needle and makes deep punctures. As a lump forms under the skin he advances the theory that he causes a mercuric albuminate, which is at first insoluble, but after becoming peptonized, enters the system.

On motion, the discussion was closed.

The Society then adjourned.

Dr. E. Leyden, of Berlin, has treated twenty cases of pulmonary phthisis at the Charité Hospital with arsenic, and as the result, reports in *Charité Ann.*, IX., 1884, that it has no value whatever in the disease, neither the general health, nutrition or physical condition of the lungs improving in the least, and not even the expectoration being favorably influenced by it.

Editorial.

State Medical Examining Boards and Endowment of the Schools as Factors in the Elevation of the Standard of Medical Education.—The tendency towards placing the control of medical practice in this country in the hands of Boards of Examiners appointed by the different States, or at least sanctioned by them, is evidently growing in favor among us. In quite a number of the States laws have been already passed to this effect, it being usual to constitute the Board of Health of any State as the Examining Board thereof. The desirability of taking the decision of a candidate's fitness to enter upon practice out of the hands of the Faculties and placing it in those of an independent Board of Examiners, having no relations with the colleges, seems too patent to need argument. It is only necessary to recall the facts that in the former case it would depend merely upon a private and usually oral examination before the individual professors, without any practical or manipulative examinations in dead-house, hospital, or laboratory, and with a strong bias in the examiners' minds in favor of the candidates.

Granting, then, the wisdom of the system by Examining Boards, how shall these be appointed? It is in the highest degree desirable that they should not merely be political appointments, conferred because of services rendered a successful candidate for Governor, or because of the mere political sentiments of the appointee. We know too well the danger which lurks in this arrangement. The Examining Board should be appointed, or at any rate nominated, by the profession or its representative, the State Society. In North Carolina it is appointed by the State Society, and by the new law of Virginia it is nominated by the State Society and the Governor cannot go outside of those nominated in making his appointments. In Germany all candidates for practice are required to pass before a Board appointed by the Government no matter from what school they have received their degree. In England the effort to secure uniformity and unity of examination has failed, and there are 19 licensing bodies there recognized by law; so that the English system differs only in degree, not kind, from ours.

Another way in which medical education, and consequently professional standing, may be advanced, is by securing endowments for the schools. Three years and a-half ago we took occasion very earnestly to urge in these pages the importance of this subject, and to point out that it offered the true solution to the problem of higher medical education. That our views were correct we have been more and more convinced, and the efforts since made by Harvard and other schools to secure endowments show that those views have taken deep root in the minds of those most interested. The last instance of private liberality towards medical institutions—the gift of a half million of dollars by Mr. Vanderbilt to the College of Physicians and Surgeons of New York—has been published far and wide, and has been received with very general satisfaction and appreciation of the donor's philanthropy. Of this gift, however, designed, as it is, merely for the purchase of land and erection and equipment of buildings, we cannot but agree that the criticism of the Sanitary Engineer is just. It says: "That there is need in New York City of properly equipped laboratories for scientific work and teaching in various branches of medicine, there can be no doubt; but whether this is the most urgent present need for medical education in this country is a question with regard to which we must answer in the negative. The most urgent need for a medical school is a sufficient endowment fund to make it absolutely independent of the fees received from students, so that it shall not be a mere business speculation on the part of the professors, holding out constant temptations to them to 'make things easy' for the students in order to attract as many as possible. At the present time there is no medical school in the United States which is so endowed as to insure this, unless we except the medical department of the Johns Hopkins University in Baltimore, and this department is not yet fully organized.

It is very natural that a wealthy donor, knowing little of what is most needed in medical education at present, should prefer to make a gift of a handsome building, which shall be a public monument of his liberality, but it is none the less to be regretted that we should not have in the commercial metropolis of the United States one medical college with well-endowed

chairs, which should require a good preliminary education of those who wish to avail themselves of its advantages, and only give its diploma of Doctor of Medicine to those who have received a training at least equivalent to that which the candidate for an M. D. from the best German Universities must have had.

The testimony of the leaders of the medical profession in this country is unanimous to the effect that we need some institutions which shall give a higher grade of medical education than is now required for the diploma of any medical school which we have, and this cannot be secured by merely providing fine buildings. The utility of these depends largely upon the teachers who are to use them; they should be first-class men who will give their whole time to the work, and aim to increase knowledge as well as to impart that which is already known. Such men must be paid and paid well; it is their whole time and thought and energy which are demanded. They should not look on their positions as being chiefly valuable as a means of advertising or as a stepping-stone to a lucrative practice, or as a means of eking out a scanty subsistence; nor should they be compelled to waste their time on the ignorant and careless, for fear that otherwise they will not get fees enough to pay for their labor."

It seems not unlikely, therefore, that Mr. Vanderbilt will find himself compelled to supplement his late gift by a further one of equal or greater amount in order to secure the full fruits of his beneficence.

While upon this subject we may add that whatever is to be accomplished in this direction must be through the private liberality of individuals. In Germany the Universities are endowed by the State, but in such a country as ours in few instances can help be anticipated with any show of reason from this source.

State Medical Examinations in North Carolina.—An interesting pamphlet has been issued by the North Carolina Board of Health, giving an account of the work done by the Medical Examining Board in that State since its institution in 1859. It appears that in that year the legislature passed a law incorporating the Medical Society of the State and authorizing it to appoint a Board of Medical Examiners. By the terms of this law, no person could practice medicine or surgery without the license of the Board, which could only be obtained by passing before it a satisfactory examination and paying a fee of $10. The members of the Board were to receive $4 a day compensation during the period of their annual meetings, which were by a subsequent amendment directed to be held at the same time and place as those of the State Society; they were also to receive travelling expenses. Any person who should practice without the above license, was debarred from sueing for or recovering a bill for his services before any court, but it was expressly declared that he was not guilty of a misdemeanor. In other words, there was practically no penalty for violation of the provisions of the law. A comparison is instituted to show the defective character of the law by contrasting it with that recently passed by the General Assembly of Virginia, Section 7 of which provides that any one commencing the practice of medicine or surgery after Jan. 1st, 1885, without registration and a certificate shall be fined from $50 to $500 for each offense and be also debarred from receiving any compensation for his services. In Alabama, Arkansas, California, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Texas and West Virginia similar laws are now in force, so that North Carolina is alone of all the States named without an effective penalty clause. Notwithstanding this serious drawback the law has not been inoperative for in that State there are intensely thoughtful and earnest physicians, zealous in maintaining the standing and interests of the profession and with enough public spirit to subordinate their own personal ends to the general welfare. These have moulded public opinion and have thus invested the law with a moral influence which (although many physicians are practicing in disregard of it) has secured for it the support and sanction of the community and thus made up to a considerable extent for its known defects.

That the law has not been allowed to be a dead letter the statistics amply prove. During the first 19 years after its passage, three successive Boards examined 122 applicants; of these 118 received a license and 4 were rejected. During the past six years the fourth Board has examined 208 applicants, and of these 183 have been granted license and 25 have been rejected, 16 of the

latter being graduates of chartered medical schools. These figures show a decided improvement in the standard required by the Board, and also an increased amount of zeal in the discharge of its duties. But there is a very natural desire among the profession to see the law improved and placed upon a par with other States which have taken action in the matter. To further this purpose, it was determined to set before the people of the State the results of the labors of the profession and at the same time to point out its needs and the necessity of revising the law. Such was the motive for this pamphlet, whose perusal we would commend to all thoughtful physicians in this community, where we are even worse off than North Carolina. It is with no small credit, as we think, that the profession of North Carolina can claim, and with perfect right too that "they have voluntarily taken upon themselves the task of working out the problem of providing the people with better doctors and so in a great measure adding to the comfort and happiness of the people and prolonging life; and, furthermore, they have undertaken the work at their own expense with no expectation of present or future pecuniary reward."

Fourth Annual Report of the Hospital Relief Association of Maryland.—This excellent charity continues to administer to the wants and comforts of that large class of the community who are compelled to seek relief and health within hospital walls. It has long ago become an established institution in our midst, whose usefulness and help are thoroughly recognized by the managers and medical staff of the hospitals. What it has accomplished during the past year in our city, is modestly set forth in this report. It is gratifying to learn that there has been an increased interest in the Association's work on the part of the public over any previous year. This work embraces the formation of libraries with printed catalogues, supplying the patients with newspapers and magazines (many of which are collected at the street corners in boxes placed there for the purpose), distribution of clothing, flowers and fruit, visiting the patients, hanging pictures and decorations in the wards, etc. As showing the zeal and influence of this association, it may be mentioned that the Home for Incurables, and the Hospital Saturday and Sunday Movement, were both its children; the former began with "the setting aside of $10 from the general fund of the Association in 1882, which has now grown to nearly $15,000 for a building fund, and about $1,200 is now on hand for running expenses." The Hospital Saturday and Sunday Association (now under independent management) has proven also a success, and will again appeal on the last Saturday and Sunday of the year to the charitable for aid for our very needy hospitals.

Announcement.—The statement made on page 10 of The Maryland Medical Journal for Nov. 1, 1884, that the entire business and editorial responsibility involved in the conduct of this Journal reverted to Dr. T. A. Ashby, is recalled as far as relates to the editorial responsibility, and until further notice, Dr. Eugene F. Cordell will continue to be associated with Dr. Ashby as joint editor-in-chief of The Journal.

Correspondence.

LETTER FROM VIENNA.

Vienna, Nov. 1, 1884.

Editors Md. Medical Journal:

Dear Sirs:—The recent opening of the Semester '84-5 of the University was marked by a great event in the history of the institution, viz: the completion of the new University building, the most magnificent of its sort in Europe. It is a structure in the Italian Renaissance style, occupying a large square of ground fronting on the Ring, and beside which many a kingly palace would sink into insignificance. Within and without everything is furnished in the most splendid, almost too princely a manner for an institution of learning. The opening exercises were conducted by the Rector, Dr. Heinrich Zschökke, before an immense concourse of students and visitors, and His Senior Majesty, the Kaiser, made some appropriate remarks.

Prof. Nothnagel's *klinik* is, if possible, more popular than in the preceding year, even the earliness of the hour (8 A. M), seems to present no drawbacks for these indefatigable seekers after medical knowledge, even the frightfully bad air, for the room is almost entirely without ventilation, which,

according to some of the theories, should contain innumerable disease germs, presents no terrors; daily three hundred and more beings are packed into the small clinic-room, never intended for over one hundred and fifty at most. What is needed is a third Professor of Internal Medicine, and I understand that in the coming year one will perhaps be called. Dr. Nothnagel has the happy faculty of making his lectures extremely interesting without introducing the slightest sensationalisms, and they are very deservedly popular. So far in the session, he has confined the clinics to the commoner forms of nervous diseases, myelitis, tabes dorsalis, etc., with the exception of showing a case of the rare acetonurie, a disease recently deeply studied by his assistant, Dr. Jaksch.

Facilities for studing psychiatrie are excellent in Wien; in the first rank comes the veteran Dr. Meynert, renowned for his discoveries in the structure of the brain. Some of his latest researches have been recently published.* His lectures are marvels of knowledge and study, and as a German student remarked, "Every word is a deep thought." Once a week he lectures on the structure of the brain, illustrated by many preparations, thus giving an opportunity to keep minutely in the memory the anatomy of that organ, an excellent plan for fitting the students for the better appreciations of the psychiatrical lectures.

Prof. Leiderdorf, of the Landes-Irrenanstalt, is the practical teacher, and through him we see all the interesting cases in the large asylum. Each has his assistants, who, in their turn, give courses, several of which are well worthy of notice.

In the obstetric wards nothing of unusual interest has recently occurred. Prof. Späth had, during the summer, two cases of cæsarian section, the first for contracted pelvis, the latter for a malignant growth filling that cavity; both cases ended fatally, the last naturally so.

There are quite a number of woman-students studying in the general hospital, a majority of whom are Americans; they are rather tolerated than approved of, and in the regular clinics are not admitted except under extraordinary circumstances. When one does appear, she is apparently looked upon by the German students as a new species of wild animal, for they gaze upon her with open mouth and eyes, and not infrequently call the attention of their comrades to the interesting animal by the pointing of canes and umbrellas towards her. It is not infrequently an interesting and amusing sight. The numbers of male American students here is truly astonishing; nearly every State is represented, Massachusetts more strongly than any other. In the special courses one hears far more English than German spoken, in fact there are so many here that the more popular lecturers courses are overcrowded. Of Scotch and English there are but few in comparison. Brazil, after the United States, sends more students here than any country of the Western world. The University of Maryland is represented by two of her graduates, respectively of the classes of 1880–1 and 1881–2.

Austrian physicians do not generally seem to be affected with the extreme degree of modesty that is shown by the New York doctors in their signs; in the cities they are of moderate size, but in the country districts occasionally rise to alarming proportions. Once this Summer I saw one in the village of St. Gilgan, in the Salzkammergut, that extended a length of fourteen paces, and was equally broad in proportion, almost covering one side of the house of its owner. Sincerely,

H. J. Berkley.

* Klinik Der Erkrankungen des Vorderheins, etc.

Obituary.

DR. HARVEY L. BYRD.

Dr. Harvey L. Byrd died in this city Nov. 29th, of pneumonia, after a short illness. He was born in Salem, Sumter county, South Carolina, Aug. 8, 1820. He received the degree of M.D. from Pennsylvania College, Philadelphia, in 1840, and again from the University of Pennsylvania in 1847. He began the practice of medicine in Salem, removing thence successively to Georgetown, S. C.; Savannah, Ga.; and Baltimore. He came to Baltimore shortly after the war, and was associated with Dr. Edward Warren and others in the revival of the Washington University Medical School, which had suspended in 1851. This venture proved a success, but in 1872 some differences arose in the Faculty which

induced Drs. Byrd and Warren to withdraw and organize another school, the present College of Physicians and Surgeons. Dr. Byrd remained attached to this school until 1874. He then resigned, and for some years had no public office. But in 1880 he joined Dr. W. R. Monroe in establishing the Baltimore Medical College. This institution still exists, although divided into two factions. Dr. Byrd had also held professorships in the Savannah Medical College and the Oglethorpe Medical College, both of Savannah, Georgia. He also edited the *Oglethorpe Medical and Surgical Journal* for three years, and was joint editor with Dr. B. M. Wilkerson, of this city, of the *Independent Practitioner*, a journal now published in New York, and devoted to the interests of Dentistry exclusively. During the late war he held the position of Surgeon in the Confederate army. He was a corresponding member of the Boston Gynecological Society, and was first President of the Epidemicological Society of Baltimore, organized during the epidemic of small-pox of 1871–3. Dr. Byrd was married twice; he leaves two children by his first wife; his second wife survives him.

Few physicians were better known than Dr. Byrd, and few have wielded a greater influence in the medical affairs of this city than he. He contributed liberally to the medical periodicals, and some of his articles had a wide circulation. He was a man of outspoken sentiments, and he thus engendered many antagonisms, but those who were his intimate associates were warmly attached to him.

Book Notices and Reviews.

Diseases of the Nose. By Clinton Wagner, M.D., New York, 1884: Bermingham & Co.

Dr. Wagner needs no introduction to the profession of this city, among whom he has many appreciative friends. In the volume before us he has not attempted an exhaustive account of nasal affections, but has simply given the practical results of his experience in the management of those diseases of the nasal passages commonly encountered in practice.

The chief value of the book resides in the fact that, unlike most of its predecessors, it does not represent a mere compilation, but is a reflection of personal experience. It may be laid down as a general rule, that the prognosis of nasal affections depends, to a great extent, upon the amount of surgery in the case; and the most brilliant results in this department of medicine have been achieved by surgical methods. Dr. Wagner has brought the treatment of nasal affections well up to recent advances in this special field, and has judiciously omitted much of the irrational and superfluous advice to which we are treated by most writers on the subject.

We cannot agree with him as to the efficacy of dilatation with nasal sounds in hypertrophy of the nasal mucous membrane, nor can we see how this method is as rational or successful as in similar troubles of the œsophagus, urethra, rectum, vagina and lachrymal duct (p. 70). For in the latter the anatomical conditions are entirely different, and, while dilatation of these passages can be accomplished without evil consequences, in the irregular nasal fossa, the amount of pressure necessary to produce absorption, is liable to produce, at the same time, caries of the turbinated bones. The procedure is, moreover, uncertain, extremely painful, tedious (extending over weeks, and even months), and not devoid of subsequent disagreeable results, and is, therefore, far inferior to a number of other simpler, quicker, less painful and more radical methods.

We are also surprised to learn that the author prefers the cumbersome Austrian polyp-snare to the more delicate and efficacious écraseur. Indeed, in the majority of cases of advanced hypertrophy, it will be impossible to introduce such an instrument through the nostril, a serious objection which we had thought had long since relegated this appliance to the limbo of museum curiosities.

We thoroughly agree with the author, that all operations in the nasal cavities requiring cutting, twisting and tearing instruments are by no means necessarily followed by alarming hemorrhage. In our experience, in the majority of instances, the hemorrhage, even if profuse, ceases spontaneously, probably from contraction of the muscular elements in the walls of the erectile cells. At the same time, however, it should be born in mind that alarming hemorrhage has occurred, and we should be pre-

pared for such an emergency. We are also fully in accord with the remarks of the author in regard to freedom from complications in the use of the galvano-cautery. In an extensive experience in the use of this agent, we have never met with any serious or disagreeable complication.

In the management of the deflected septum, Dr. Wagner prefers the revolving knife and burr of the surgical engine, a procedure which he and Goodwillie have used with gratifying results.

The book closes with notes of cases selected from various medical journals, and with a good bibliography of recent contributions to rhinological literature.

Evidences of haste in preparation occasionally occur and typographical errors are not infrequently met with; but these are of minor importance. In other respects the publisher's work is creditable. We congratulate the author upon the successful completion of his work, which we recommend to the profession with the assurance that they will find in it much to interest and instruct. J. N. M.

BOOKS AND PAMPHLETS RECIEVED.

A Handbook of of Ophthalmic Science and Practice. By Henry E. Julier, F.R.C.S., Junior Ophal. Surgeon to St. Mary's Hospital of London, etc. With one hundred and twenty-five illustrations. Philadelphia: Henry C. Lea's Son & Co., 1884. Cushing & Bailey. pp. 467.

Transactions of the Louisiana State Medical Society. Sixth Annual Session, held May, 1884.

Transactions of the Medical Society of the State of California during the years 1883 and 1884.

Proceedings, Addresses and Discussions of the Kentucky State Sanitary Council. Third Semi-Annual meeting, held March, 1884.

Poisoning by Canned Goods. By John G. Johnson, M.D., of Brooklyn, N. Y.

The Treatment of Diabetes Mellitus. By Austin Flint, Jr., M.D., Prof. of Physiology in the Bellevue Hospital Medical College.

The Dry Treatment of Chronic Suppurative Inflammation of the Middle Ear. By Charles J. Lundy, A.M., M.D., Prof. of Dis. of Eye, Ear and Throat, Michigan College of Medicine, Detroit.

Muriate of Cocaine in Ophthalmic Surgery. By C. J. Lundy, A.M., M.D.

Text-Books of Medical Jurisprudence and Toxicology in the University of Pennsylvania, etc. Philadelphia: B. Blackiston, Son & Co. 1884. Pp. 600.

Miscellany.

Micrococci in Relation to Wounds, Abscesses, and Septic Poisons. *Mr. W. Watson Cheyne*, in a report to the Scientific Grants Committee of the British Medical Association (*Brit. Med. Jour.*, Sept. 27th, and Oct. 4th, 1884) sums up the following as the "chief points of interest" in his paper:

1. There are various kinds of micrococci found in wounds treated aseptically, differing markedly from each other in their effects on animals. They agree in growing best at the temperature of the body, and in causing acidity and sweaty smell in the fluids in which they grow. The experiments show that cultivations may be carried on in fluids with accuracy, provided the precautions mentioned be observed.

2. The micrococci tested in these experiments grew best in materials exposed to oxygen gas. They grew only with difficulty in the absence of oxygen. Eggs were not good pabulum.

3. Their effects on animals was not altered by growth with or without oxygen.

4. The effects of these micrococci on rabbits and man were not similar, some of the most virulent forms for rabbits causing no deleterious effects in wounds in man.

5. The kidney is apparently an important excreting organ for organisms.

6. Organisms not capable of growing in the blood may yet cause serious effects by growing in the excretory canals. This may explain some cases of pyelitis.

7. Where an organism is not markedly pathogenic it may be necessary to introduce a large quantity before morbid changes are set up.

8. Suppuration is not always due to micrococci; it may be caused by chemical irritants, such as croton oil.

9. Micrococci are always in acute abscesses and are probably the cause of them.

10. In some cases, the micrococci are the primary cause of the inflammation and suppuration, as in pyæmic abscesses; gen-

erally, however, they begin to act after inflammation has been previously induced.

11. This inflammation may be caused by an injury, by the absorption of chemically irritating substances from wounds, by colds, etc.

12. There are several different kinds of micrococci associated with suppuration.

13. Micrococci cause suppuration by the production of a chemically irritating substance, which if applied to the tissues in a concentrated form causes necrosis of the tissue, but if more dilute, causes inflammation and suppuration.

14. The conditions in wounds and abscesses are not the same, inasmuch as in the former there is opportunity for mechanical and chemical irritants to work.

15. There is no reason for denying the existence of antiseptic suppuration.

16. Tension may also cause suppuration but it is perhaps most frequently aided by the growth of micrococci. These organisms need not be of a very virulent kind. It is also probable that the products of inflammation are themselves irritating and capable of existing or keeping up inflammation.

17. The micro-organisms of septicæmia, of pyæmia, of erysipelas, are different from one another and from those of abscesses. In erysipelas, the micrococci grow in the lymphatic spaces. In pyæmia they grow in the blood to form colonies and emboli. In septicæmia they may only grow locally, the symptoms being due to the absorption of their ptomaines; or if they grow in the blood, they do not form colonies and emboli. Septicæmia may also be due to other organisms besides micrococci.

18. There are no facts to support the view that it is the same micrococcus which under different conditions causes these various diseases. The experiments of conversion of innocent into malignant forms and *vice versa* are unreliable.

Antiseptic Ovariotomy.—*Mr. Knowsley Thornton*, at the Samaritan Free Hospital, London (*Brit. Med. Jour.*), Oct. 25, has had but three deaths in his last one hundred ovariotomies. Of the fatal cases, one was an elderly woman with malignant disease of stomach, liver and rectum. In a second, fatal hemorrhage followed the slipping of a ligature; much blood was lost before it was discovered and she never rallied. In the third fatal oozing occurred, from the pelvic tissues after enucleation of a tumor from its capsule, which could not be checked. Mr. T. had also successfully performed nephrectomy eight times in succession; also one nephrotomy, one nephro-lithotomy, and several cases of removal of uterine appendages. He regards these results as a complete vindication of the value of the strict antiseptic method (including the spray). There had been no blood-poisoning, although pyæmia and septicæmia prevailed in adjacent wards. He used drainage in only one of his ovariotomies (a case where the ureter was wounded and urine escaped into the peritoneum), and thinks, with careful antisepsis, the drainage tube unnecessary, and septicæmia removed from the causes of mortality. In no case had any serious symptoms been observed which could be ascribed to the absorption of carbolic acid, although many were severe and prolonged operations, one lasting 3¼ hours.

Shoemaker on Oleates.—I would sum up by stating that although the Oleates have not been found to fill the place they were originally intended for by those who introduced them to us, they have made for themselves a most prominent place amongst the more scientific means which we possess for treating affections of the cutaneous covering. They have opened up a new era for therapeutics in that branch of medicine and occupy a position that has not been held by either ointment or lotion, and which they will occupy not only in a transitory manner, but permanently and in an increased ratio, as their nature, use and effect will become more thoroughly understood and known.—*Brit. Med. Journ.*, Oct. 18.

Treatment of an Attack of Gout.—Prof. Dujardin-Beaumetz says in the *Med. News*, Oct. 18, 1884:

To sum up then, when you are called to treat an attack of gout, you will first assure yourself of the integrity of the kidneys, then you will administer salyiclate of soda in doses of from one to one and a half grammes, or, if you prefer, the tincture of colchicum seeds combined with quinine or strong tincture of aconite root. If, on the contrary, the kidneys are damaged, or if the heart seems to be degenerated, you will have to content yourselves with giving alkaline diluents and keeping the bowels

open with saline purgatives; besides enswathing the affected member with wadding, around which is placed oiled silk.—*Med. and Surg. Reporter.*

Medical Items.

Australia refuses to recognize American medical diplomas.

Dr. Lewis A. Sayre is suffering from a prolonged illness.

A dispatch from Paris, of Nov. 24th, announces that the cholera epidemic there is at an end.

Dr. John P. Gray, of Utica, was elected President of the New York State Medical Association for the ensuing year.

The Medical School of the National University, the new "day" school of Washington, is said to have eight or ten students.

According to the *Medical Record*, the prophylaxis of cholera is expressed in three phrases: Rational quarantine, municipal cleanliness, personal hygiene.

At the recent meeting of the New York State (old code) Medical Association, resolutions were adopted for the formation of a library in New York City.

Dr. Jas. F. Hartigan has been appointed Lecturer on Diseases of Children, and Dr. Jno. W. Bayne, Professor of Clinical Surgery at Georgetown University.

The *New York Med. Record* urges the holding of an International Hygienic Exhibition in New York, similar to that so successfully held recently in London.

Dr. Paul Grawitz has declined the position of Director of the Carnegie Laboratory and Professor of Pathological Anatomy in Bellevue Hospital Medical School.

There are eighty-thousand cess-pools in Paris, and, according to the *Lancet*, the sanitary condition of the city is very bad. The houses average forty inhabitants each.

M. Fauvel died in Paris, Nov. 5th, of double pneumonia, in his 72d year. He was Inspector General of the sanitary service, and Vice-President of the Academy of Medicine.

The number of students at the Cincinnati medical schools has fallen off about thirty per cent. in each. The cause assigned for this is the requirement of preliminary examination on entrance.

The Quarantine and Health officers of the principal cities of the United States will meet in Washington, Dec. 10th, to take action looking to the prevention of the importation of cholera into this country.

The Italian physicians declined to volunteer their services in the recent cholera epidemic, unless they were placed upon an equality with the army officers, which would ensure them a pension for their families in case of their death.

Muriate of ammonia (chloride of ammonium), is best administered in solution diluted at the time of taking with very cold water, and the ordinary dose to begin with is about ten grains three or four times a day. *Squibb.*

Col. George E. Waring, Jr., has resigned the Secretaryship of the National Board of Health, and Mr. W. P. Dunwoody, life disbursing clerk, has been appointed his successor. Dr. Hosmer A. Johnson, of Chicago, has also resigned from the Board.

The International Health Exhibition of London closed October 31st. From May 8th, the opening, to October 31st, there were 4,167,683 visitors, 71,854 having entered on one holliday in August. The net receipts were $200,000, and the question is, what shall be done with it?

The New York State Medical Association, the new society which had its origin last Spring, in consequence of the ethical dispute, held its first annual meeting in New York city, Nov. 17–19. According to the *Record*, the meeting was a great success, the attendance of out-of-town physicians being especially large.

The Baltimore Academy of Medicine prize of $50 for the best paper read before that Society during the past year has been awarded to Dr. Jno. N. Mackenzie, of this city, for his paper, entitled "Irritation of the Sexual Apparatus as an Etiological Factor in the Production of Nasal Disease," an abstract of which appeared in the MARYLAND MEDICAL JOURNAL of January 26th, 1884.

Original Articles.

SUPPURATIVE ARTHRITIS — ITS CONSERVATIVE TREATMENT.

BY C. B. NANCREDE, M.D.,

Professor of General and Orthopædic Surgery in the Philadelphia Polyclinic; Surgeon to the Episcopal and St. Christopher's Hospitals.

This paper in reality consists of the brief notes of a case of incised wound of the knee-joint, and the elaborate history of a second case of suppurative arthritis of the wrist-joint. For the history of the latter I am indebted to Dr. Ralph W. Seiss, the family attendant of the patient, to whose unremitting and intelligent care a large share of the recovery must be attributed. Instead of dilating upon the indications for treatment in cases of suppurative arthritis, I will simply let the histories of the cases speak for themselves.

On Saturday, March 25, 1882, I was asked to see J. P. R., æt. 28 years, a patient of Dr. T. S. Crowly. The doctor had first seen him on that day, and had at once directed him to send for me, recognizing the exceeding gravity of the case. J. R. had, the previous Thursday afternoon, cut his right knee with the corner of his hatchet, when the limb was strongly flexed, thus rendering the incision into the capsule non-coincident with that through the skin when the joint was in any other position than extreme flexion; in other words, the joint was opened in a so-called valvular manner. Owing to a nick near the corner of the hatchet, the weapon must have incised the capsule fully to the extent of a fourth of an inch. He at once tied a "chew of tobacco" over the wound, and did some light work until the evening, when he rode home. The next day he returned to his work, which happened then to be light, but unfortunately he walked home, about two miles, which caused enough pain and uneasiness in the joint to induce him to stop to rest several times before reaching home. That evening he still persisted in walking around, without experiencing much uneasiness, and, retiring early, was awakened by very severe pain in the joint, which was red and swollen. Chills, high fever and slight delirium rapidly supervened. When I first saw him, the joint was filled with fluid, and the periarticular tissues were swollen and reddened. Rest and ice with opiates utterly failed to control the symptoms, so that by Sunday night the patient was very ill, with a manifestly suppurating joint. Some synovia mingled with pus issued from the incision, both with and without pressure. Upon consultation with Prof. Ashhurst, I freely laid open the original wound upon a director, and then made a free incision upon the outer, upper side of the patella, thereby giving vent to a quantity of purulent synovia. The patella came into contact with the femoral condyles, so that no extended search was made for the opening in the capsule. A poultice was applied and morphia exhibited. The next morning the joint had again filled up, but on a second visit the discharge had again found vent, allowing the patella to recede to its normal position. The whole lower half of the thigh and the region of the head of the tibia was converted, within a few days, into a series of abscesses more or less intercommunicating. Suffice it to say, that by free counter-openings, drainage-tubes, antiseptic injections, and immobility of the joint secured by splints and suspension from the ceiling, aided by a proper supporting regimen, with free stimulation, quinine, etc., the patient convalesced. Hot douching, massage and passive movement, in a few months brought the knee to a right angle, and now perfect extension and nearly perfect flexion have been attained. The members will see that the patient walks absolutely without any limp, with a freely moving, normal joint, which never reminds him of previous trouble, except by passing fatigue, although he tells me that he has formed such a habit of "favoring" his knee as to make him afraid to exert it much, unless he forgets all about it, when he uses it as freely as ever before. Such a result speaks for itself.

In this case there is no reason to doubt that the immediate application of a compress and bandage in the form of the "chew of tobacco" and the handkerchief excluding the air, the ride home and the night's rest, all favored primary adhesion of the capsular wound. The next day's work, light as it was, with the walk home and the subsequent evening's exercise, doubtless reopened the recently healed capsule, air was probably pumped in by the movement of the joint, and suppuration ensued. Perfect

* Read before the Philadelphia County Medical Society, November 19, 1884.

quiet of the joint from the moment of reception of the wound, its disinfection and antiseptic dressings, aided by cold, would doubtless have obviated all the subsequent danger and suffering.

I shall now read the notes relative to the case of suppurative arthritis of the wrist and inferior radio-ulnar joints, kindly furnished me by Dr. Seiss.

On April 24, 1884, I was called in the case of Mr. W., a large, powerful man, of splendid constitution, and perfect family history; a builder, he had led an active, out-door life, and had been of regular habits up to within a few years, since when he has been drinking somewhat heavily. One week before I saw him, while wrenching the stopper from a bottle the neck broke, and the keen edge of the larger fragment, in slipping, cut the ulnar side of his right wrist, producing a wound down to the joint capsule, and about an inch in length. After allowing the free venous bleeding to continue some moments, he forcibly strapped the wound with many layers of court-plaster, applied over this a tight bandage, and then soaked the entire dressing with "Turlington's Balsam." To ease the terrible pain he suffered, he says he consumed about a quart of whisky in a single day, and almost as much the succeeding day. He was given calomel and a "fever mixture" by a local practitioner at Atlantic City, N. J., where the accident occurred, and some five days after the receipt of the injury, was removed by his relatives to Philadelphia.

When I saw him, his hand was encased in a clumsy poultice, on removing which I found the wound partly filled by friable granulations. On examination with a probe and my little finger, I could plainly feel the capsular ligament, which appeared uninjured; the ulnar artery was also found to be intact; the motions of the wrist-joint were still free. His temperature was 103°; his skin clammy and leaking; tongue foul and coated; respiration hurried; pulse rapid and weak; mind clouded, with a marked tendency towards muttering delirium; his urine was found, on examination next day, to be loaded with albumen. The entire hand and lower forearm were covered with a fiery red blush; the hand was much swollen and puffy. I at once enveloped the entire hand and forearm in a dressing of laudanum and water, equal parts, and placed it upon a forearm-splint. I put him upon two grains of sulphate of quinine every two hours, night and day, each dose to be followed by a half ounce of whisky in an ounce of milk—which was increased to three ounces of milk as soon as the stomach was found to bear well the first few doses. I also ordered him to be sponged daily with a solution of alum in alcohol and water.

For seven days after the adoption of the above treatment he grew steadily better, with less sweating, a stronger pulse and respiration, a lower temperature, and his mind was clear. On the evening of the seventh day, his temperature rose rapidly to 103°, and continued to rise, with slight morning remissions, until it reached 104⅓° on the evening of the tenth day. I then found a small abscess forming over the first and second metacarpal bones, which I at once opened by a free incision—permitting the escape of about half an ounce of creamy pus. He immediately improved, but shortly after commenced to have marked night-sweats, with great pain in the hand and forearm, requiring the frequent administration of hypodermic injections of morphia sulphate, to secure rest at night. About a week after the formation of the first abscess, I opened another, situated between the thumb and index finger, by a deep incision, giving vent to a thin glairy pus. This, however, produced but a slight remission of the symptoms, and he rapidly fell into a semi-typhoid state. A few days after the opening of the second abscess, Prof. C. B. Nancrede saw him in consultation with me. The following conditions now obtained: Careful manipulation gave a slight sensation of grating, showing the presence of eroded bone; examination with a probe showed extensive destruction and separation of tissues, the hand being little more than a bag of bones; the wrist-joint was stiff, and gave distinct crepitus on motion. The original wound was covered by exuberant granulations. General condition markedly septic and typhoid. A counter-opening was now made on the radial side of the wrist, a grooved director being passed through my incision over the second metacarpal, which had been kept freely open, directly through the opening. The pulsation of the bared artery (radial) could be plainly felt under the director. Upon suggestion of Dr. Nancrede, the hand was now

enveloped in dressings of hydrarg. bi-chloride, one part to 2,000 of boiled water, and three-drop doses of tincture ferri-chloridi were given every two hours, in addition to the treatment already adopted. This caused a slight amelioration in the symptoms. Thorough drainage was maintained by the use of drainage-threads of ligature silk, and all the openings were carefully syringed twice daily with the hydrarg. solution. The quinine and whiskey were continued, together with hot broths and concentrated foods of all kinds. His average morning temperature was now 101½°, his evening rise from one degree to two and a quarter degrees; pulse always rapid and feeble—from 98 to 117; respirations hurried; mind clear; took food willingly; had occasional fits of restlessness and pain, requiring hypodermics of morphia; some night-sweats; a trace of albumen constantly found in urine, but no casts could be found at any time. For two weeks this state of things continued with but little change for better or worse. Then commenced a train of markedly septic symptoms; lungs frequently congested; some cough; marked night-sweats; hurried pulse and respiration; furred and heavily coated tongue; intense pain in hand; urine loaded with albumen; occasional, though rare, chills. Some fourteen days after the first consultation, his temperature began to rise steadily until it reached 105° on the sixteenth day after our first consultation, and he now failed so rapidly that I feared speedy death from exhaustion.

On the evening of the sixteenth day I discovered a deep-seated abscess over the distal ends of the ulna and radius. The same evening I again saw him with Dr. Nancrede, when the following operation was performed: Dr. Nancrede made a free incision over the abscess and dissected down on a director until the joint was reached, the latter was opened, and about a half ounce of pus allowed to escape from it.

On examination with the probe and finger, the articular surfaces of the inferior radio-ulnar joint were found to be deeply eroded. The bones of the proximal row of the carpus and the articular surface of the radius were also found to be softened and partially denuded of cartilage. A director was pushed through the radio-carpal joint until it could be felt under the skin on the dorsal aspect of the wrist, where a free counter-opening was made down upon it. The wound was now thoroughly syringed with the hydrarg. solution and a stream of the latter forced through the radio-carpal joint, moderately forcible extension being made to facilitate the passage of the solution. The hand was now most carefully cleansed with the antiseptic solution and antiseptic irrigation was used, the hand and forearm simply resting on a bed of raw cotton, covered by lint kept constantly soaked with the bi-chloride solution; the amount of whisky he had been taking steadily since I first saw him was increased and the dose of quinine raised to twenty-eight grains per diem. The night of the operation he suffered intense pain in the hand, requiring two hypodermic injections of morphia, each of one-quarter grain, to produce quiet.

With the exception of one or more small abscesses on the dorsal aspect of the hand, which I opened, and its attendant symptoms, and a troublesome pressure-sore on his elbow, he now steadily improved. It having been found absolutely necessary to open the sheath of a tendon—palmaris longus (?)—in opening the joint, some slight trouble occurred from hernia of the tendon, it occasionally extruding to the extent of nearly two centimetres; it was carefully returned at each of the two daily dressings, and attempts made to keep it in place by a compress lightly applied. It perfectly returned to its normal position as the wound closed. A large amount of bloody synovia could be pressed from the sheath of this tendon at each dressing. In ten days h was able to sit up for a short time, and the doses of both quinine and whisky were now lessened. After some weeks of treatment with the bi-chloride solution, he exhibited marked mild mercurial poisoning, and carbolic-acid solution, one part crystals to forty-five of boiled water, was substituted. In three weeks the arm was put upon a wooden forearm-splint, still enveloped in wet carbolic-acid dressings, and he was able to move about his room. About a week later he went down-stairs for the first time. The quinine and alcohol were now reduced to tonic doses. The wounds were now completely blocked with healthy granulations and, therefore, the wet carbolic-acid dressings were discontinued, the wounds being dressed with carbolized cosmoline—one to forty, pure crystals—and later with oxide of zinc ointment. Passive motion was now

made for some minutes, night and morning. After some three weeks of this treatment, *thirteen weeks* after receiving the injury, he was able to leave the house for a short walk; and *fifteen weeks* after the accident he was able to go about and attend to his affairs almost as usual, wearing his arm on an accurately moulded splint of binder's board, with the wounds entirely healed.

I now saw him but three or four times weekly, and at each visit thorough friction with alcohol on a handful of raw cotton, thorough massage and passive motion of the entire arm were practiced. The elbow was now exceedingly stiff, the shoulder-joint equally so, the wrist anchylosed, thumb almost rigid, only slight motion of the fingers. The binder's-board splint was now soon abandoned and he was instructed to make constant efforts to move all the joints of his arm, forearm and hand. I saw him weekly and made strong passive motion of all the stiffened joints at each visit.

At present, six months after accident, his condition is as follows: Weight, 185 pounds —being a gain of twenty-six pounds in about nine weeks—general health good; some neuralgic pain in injured hand occasionally; shoulder slightly stiff, deltoid muscle unable to lift it to normal height. Elbow stiff, but hand can be brought directly back to within eight inches of the shoulder —which, the wrist-joint being anchylosed, is almost normal. The forearm cannot be pronated nor supinated, save to a very slight extent. The wrist-joint, as a whole, has a slight degree of extension and flexion. The fingers have more than three-fourths normal flexion and extension, and that quite free. The thumb has its free movements, and is but very slightly stiffened. He writes, with the injured member, a very fair hand, and can continue its efforts long enough to write four pages of "legal cap" without rest. The hand can also be rapidly used for all ordinary purposes not requiring much strength. He feels changes of the weather badly in the entire right arm, but apart from this, the occasional neuralgia and a feeling of weakness and tenderness in the member, uses it as freely as the other uninjured hand.

In conclusion, I would reiterate that free incision, drainage and rest, combined with antiseptic treatment in its broadest sense, will, when judiciously followed by persistent passive movement and massage, often save not only live and limb, but an excellent joint, such as I show you in these two cases to-night.

TWO CASES OF ACUTE MILIARY TUBERCULOSIS.

BY GEO. J. PRESTON, M.D., BALTIMORE.

Late Resident Physician, Presbyterian Hospital, Philadelphia.

The symptoms of acute tuberculosis are often very obscure, and simulate so closely those of other affections that it becomes a difficult matter to make a positive diagnosis. The typical case is familiar, but the two following cases, the one nearly resembling chronic Bright's, and the other typhoid, may prove interesting from a diagnostic point of view.

Case I. Matilda F., aged about 28, a native of Ireland, was admitted into the hospital shortly after reaching this country. She gave a very good family history, and dated the beginning of the present attack to some time during the voyage. Her temperature was of a very irregularly remittent type; nausea and vomiting were very distressing and persistent, not yielding to any of a great variety of remedies tried. Diarrhœa alternated with constipation, but there was not the slightest tympany and no tenderness even on deep pressure over the abdomen. The urine was passed frequently, and was rather more than normal in quantity, showing a small per cent. of albumen and hyaline tube-casts. Auscultation of the chest showed a few rales resembling bronchitis in the finer tubes. The pulse was rapid and weak. There was total anorexia and rapid loss of strength and flesh. These symptoms continued, without any important variations, until her death, which occurred about three months after being admitted to the hospital.

The autopsy showed a very marked case of acute tuberculosis. The peritoneum was so thickly studded with miliary tubercles that the end of the finger could hardly be put on a spot free from them. The folds of the intestines were firmly bound together by bands of lymph, and the capsules of the kidneys, spleen and liver were covered with

the deposit. Tubercles were found in the lungs, but there were no cavities in, nor breaking down of the lung tissue. This case resembled chronic Bright's disease in the following points: persistent nausea, frequent micturition with increased amount of urine, albuminuria with tube-casts, rapid loss of flesh and a marked cachexia. It is to be noted that there was no tympany, nor tenderness over the abdomen, generally very prominent symptoms in this disease.

Case II. Thomas J., colored, aged about 35. No distinct family history of phthisis. The patient had been suffering from general malaise about a week previous to admission into the hospital. His symptoms at first were: headache, pain on pressure in the right iliac fossa, though not confined strictly to that locality, marked tympany, diarrhœa, with stools closely resembling those of typhoid fever, temperature high, with morning remission, expression dull and listless, and a muttering delirium. The tongue, at first covered with white fur, became brown and cracked, and sordes accumulated on the gums. Being a negro, the spots were not looked for, and the case was regarded as an ordinary one of typhoid fever.

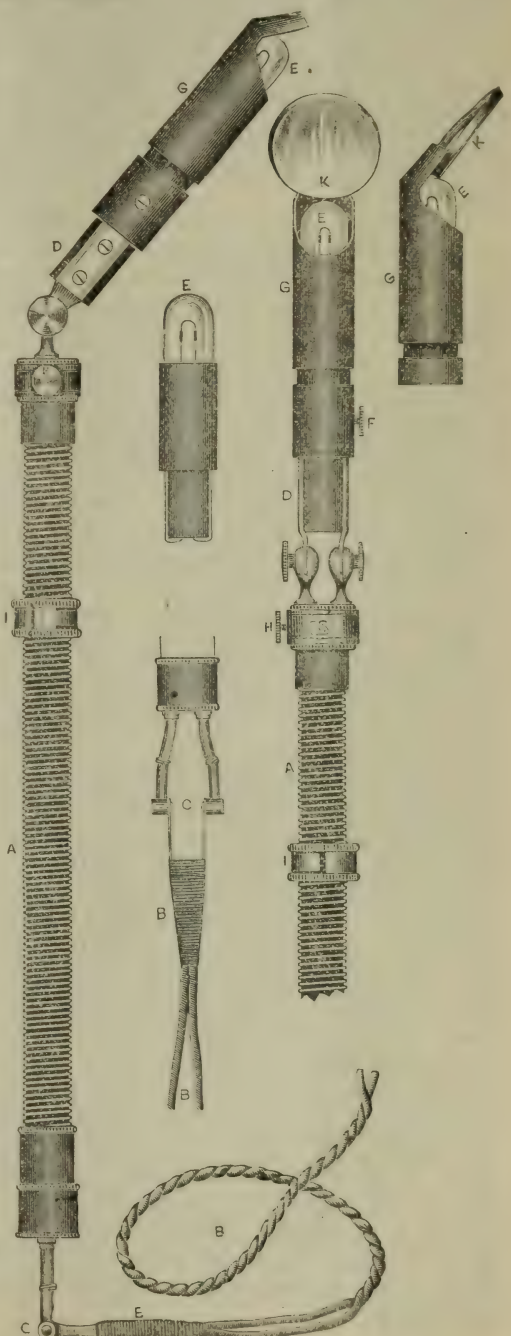
The duration of the case was about three weeks, and the autopsy revealed a peritoneum covered with miliary tubercles, which were also scattered through the lungs, though no dullness could be detected during life, and there were very few rales. The intestines were slit up and one or two tubercular ulcers were found.

The treatment in these cases amounts to nothing and must be merely palliative, as the result is inevitably fatal. There have been a number of cases of this disease reported as cured, especially by English physicians, but the nature of the affliction, and the difficulty in making the diagnosis render it extremely improbable.

The diagnosis of the disease, however, has its practical aspect, since it is liable to be confounded with affections of a totally different nature, as the above cases may show. Besides, it is very much more satisfactory to a physician to know that he is vainly fighting an incurable disease than to suppose he is dealing with one which depends largely on his skill for its happy result.

AN ELECTRIC MOUTH-LAMP AND LARYNGOSCOPE.*

Dr. Laurence Turnbull, assisted by Dr. Starr, exhibited the above instrument as an illuminant of the cavities of the ear, nose, and throat.



The advantages claimed for this instrument, which is manufactured by the S.

S. White Dental Manufacturing Co., are: Its small size, enabling it to be placed behind the object to be lighted up, which then becomes translucent, thus showing pathological changes in structure; with a laryngoscopic mirror it can be placed over the tongue, thus lighting up the larynx directly; being of small bulk, it can be readily and frequently plunged into a glass of ice-water for cooling purposes, and ingenius rheostat in the handle enables the proper battery force to be selected without danger to the filament. The following is a description of lamp:

The lamp E, is an incandescent electric light, mounted permanently in a non-conducting case or cylinder of hard rubber. The lamp is supplied with metal conductors which pass outside of the section of the case. The lamp case is carried in another hard-rubber cylinder, D, called the lamp-holder, which is also supplied with metal conductors fitting those on the lamp case, the two parts when adjusted being clamped together by the set-screw, F, thus holding the lamp firmly in its socket. The conductors of the lamp-holder are connected to the handle, A, by hinged joints, so that almost any desired adjustment is readily secured. This handle is called a resistance handle, because it is wrapped with wire of a low conducting power, by which, through the agency of the ring. I, the flow of the current is regulated. When the ring is placed at the end of the handle nearest the battery-cord, the resistence is reduced to the minimum and the current from the battery flows freely to the lamp. Sliding the ring to the opposite end of the handle compels the current to travel through the wire with which the handle is wrapped to the ring and back again, thus forming a resistance. The connection to the battery cord, B, is made by the spring-coupling, C. A non-conducting guard or shield, G, is placed over the lamp-globe for the double purpose of preventing the radiation of the heat, and of directing the light to any point desired. At H is a screw for breaking the circuit. The circuit should be broken occasionally during a prolonged examination, and also whenever the lamp is not in use, to prevent its becoming so hot as to be unbearable in the mouth.

For the examination of posterior cavities, a mirror set at an angle of forty-five degrees is attached to the end of the guard. With the mirror attachment, the Electric Mouth-Lamp forms a laryngscope.

Dr. Turnbull observed that this was the most satisfactory Incandescent Electric Lamp, with which he has examined the aural or oral cavities. The light is soft white and of great brilliancy; it can be employed as a direct light, by holding it in the hand like a candle, and by placing a speculum in the ear it can be concentrated upon the auditory canal, or illuminate the membrana tympani. He then illustrated its use upon three patients, showing in the first the canal filled with impacted cerumen; in the second, a narrowing of the canal with desquamative epithelium, and in the third an inflamed membrana tympani. Again, by having the mirror attached in front, he examined a fourth patient's pharynx, eustachion tube, and, by turning it downwards, his larynx. In still a fifth, he, with the light, illuminated the nose and side of the cheek, the teeth, gums and outlines of the bones, showing any decay or foreign substance, by placing the lamp behind the object. To develop the full capacity of this electric light, it only requires about three and one half to five volts—or a current of three cells of a "Bunsen battery." Another advantage is its small size, and being mounted permanently in a non-conducting case or cylinder or hard rubber.

* From the Proceedings of a Recent Meeting of the Philadelphia County Medical Society.

Society Reports.

CLINICAL SOCIETY OF MARYLAND

STATED MEETING HELD NOV. 28TH, 1884.

(*Specially Reported for Md. Med. Journ.*).

The President, DR. B. B. BROWNE, called the Society to order at 8.30 P. M.

The first paper was by *Dr. R. M. Hall*, entitled

SEVERAL CASES OF PELVIC CELLULITIS.

"Case I. M. B., aged 35. When called found her suffering pain in right foot and lower part of abdomen, with fever. Menses appeared on the following day. She had suffered from abdominal pains for a long time; she was examined at a dispensary with speculum and sound; the next

day she had a chill and fever. When I examined her I found her with pelvic trouble, the temperature was 101°, with rectal tenesmus, which was controlled by an opium suppository. From Sept. 23 to Oct. 7 she had a temperature from 101° to 103°. Had tympanites, and at times had difficulty in micturition, so much as to require the use of catheter. Vagina hot and in Douglas's cul-de-sac there was found a sac which was tender on pressure. Over the pubes a hard body was felt which was thought to be the uterus antiverted. Dr. B. B. Browne was called in, at which time the patient had become quite weak, with persistent rectal tenesmus, with a frequent and feeble pulse. He advised the opium suppositories to be continued, and a blister to be applied to lower portion of abdomen and the raw surface to be sprinkled with morphia. The sac was opened by Dr. Browne *per vaginum* about the fourth visit, and a half pint of offensive pus discharged, after which both sac and vagina were washed out with carbolic acid solution. Stimulants, with quinine, were given, and she continued to improve and was finally discharged. I was called to see her a second time and found her with high fever, loss of appetite and headache; an offensive pus was soon afterwards discharged from vagina, after which her pulse became normal and all the symptoms improved. At present the sac is being painted with iodine."

"Case II. A. A., aged 35. Was called and found her suffering from a chill, with vomiting and pain in lower part of abdomen. A catheter had to be used for dysuria. Gave her quinine and opium. Found temperature next day (Sept. 27) 102°, with severe pain in the abdomen, rectal tenesmus and appearance of the menses. On Oct. 5 menses had ceased, and upon examination the vagina was found hot and dry, the uterus tender, and to the left of the organ a hard, firm swelling Larges injections of warm water were ordered. The symptoms soon began to improve, and an examination on Oct. 15 revealed a normal vagina, the swelling somewhat tender, but much diminished in size. She was discharged on Oct. 20."

"Case III. Was called to see this patient in October; found her with colicky pains in abdomen, and tympanites, also vomiting. Menses soon appeared and were profuse. The troubles continued in spite of quinine and morphia. On Oct. 9, when menses ceased, opium suppositories were used, which controlled the vomiting and diarrhœa. An examination found the uterus tender and a swelling in Douglas's cul-de-sac. Copious warm water injections were ordered, the symptoms began to improve until she was discharged."

"In the first case it was absolutely necessary that the abscess should be opened. The first and second case were child-bearing women, while the third case had never been pregnant; in all these cases the uterus had become fixed."

DISCUSSION.

Dr. Ashby said the most trivial causes are often sufficient to give rise to pelvic cellulitis, as the mere introduction of a sound, operation for lacerated cervix, &c. He then quoted from Dr. Thomas as showing the causes in certain cases. In four cases of his own the trouble occurred in virgins. The doctor said he made it a rule, before introducing the probe, to inquire if any trouble of the kind had existed previously.

Dr. Rohé said in the majority of cases the opportunity was afforded for the absorption of septic material, as in the various operations which preceded the outbreak of the trouble.

Dr. Chunn related the following: A woman came to him with pelvic trouble. She had but little fever and pain during defecation; upon examination *pervaginum* a fluctuating tumor was felt. A hypodermic needle was introduced, and instead of pus a clear, watery fluid was withdrawn resembling serum; a cyst was accordingly diagnosed, and the patient kept under observation. The tumor increased in size, and finally ruptured with the death of the patient. The autopsy revealed a pelvic abscess. But one sac was found, and the doctor was at a loss to explain the serum he withdrew, though possibly the serum had formed first and pus afterwards, or that the cyst had become an abscess after his examination. In all cases where pelvic trouble ends in suspected suppuration the hypodermic needle should always be used to render diagnosis certain.

Dr. Hall thought, and quoted Dr. Thomas, that under any circumstances the pus or serum should have been evacuated.

Dr. B. B. Browne thought the serum might occur in the sac of an old abscess, but that the serum could not precede the pus. He instanced Dr. Brincknall's case, where both cysts and abscesses were found in the broad ligaments, but both separate and distinct from one another.

Dr. Councilman thought a cyst was always a cyst with its cavity lined by cyliated epithelium, and that the sac of an abscess could not be converted into a cyst if let alone.

Dr. Tiffany agreed with Dr. Browne, that in Dr. Brincknall's case the cysts and abscesses were distinct. He thought the two conditions, cysts and abscesses, distinct. A cyst can become an abscess only from interference, as the puncture with a needle, &c.

Dr. Ashby related the case of a patient who had an abscess opening into the vagina which resulted in an apparent cure; the patient subsequently exposed herself to a cold which induced a second attack of pelvic inflammation. An abscess formed and discharged into the rectum. The patient finally died from the disease. He thought a cautious prognosis should be given in a case that had suffered from pelvic inflammation. The readiness with which the disease may be re-established should make the medical attendant cautious in examining and operating upon these cases.

Dr. Branham related the case of a patient of middle age who suffered with inflammatory trouble about the pelvic organs from exposure. A tumor was felt at the side of the uterus, which gradually increased to the size of a child's head. Could get no fluid nor fluctuation, though the needle was used several times. The symptoms soon subsided, the tumor gradually diminished, but no pus was at any time discharged.

Dr. Scharf thought possibly Dr. Chunn might have had to deal with a pelvic peritonitis at first.

Dr. I. E. Atkinson thought Dr. Chunn might have put the needle into a part which was not the abscess, but a serous collection outside; he did not believe he could have drawn serum from an abscess.

Dr. Chunn thought there might have been some cellulitis. Dr. Neale had saturated some absorbent cotton with water, squeezed it almost dry, introduced a needle into it, and succeeded in drawing off some water.

PERFORATION OF THE UTERUS BY THE EXAMINING SOUND

was the title of the next paper read by *Dr. W. P. Chunn.*

He gave the history of nine cases in which the uterus was shown to have been perforated, or in which all the indications pointed that way. (See the JOURNAL of Nov. 22, 1884).

Dr. Councilman did not think it often that we could prove certainly that a uterus had been perforated, the patient still living; but he instanced a case in which a patient died of peritonitis four weeks after delivery, in whom the uterus had been perforated by a sound.

Dr. Ashby said in one case he had penetrated the uterus; in this case an abscess opened into the uterus from above, and when he introduced the sound it went in up to the handle. Pus followed its withdrawal. The uterus had probably been ulcerated through.

Dr. Branham thought the use of the curette might explain the trouble in Dr. Chunn's first case.

Dr. C. Hampson Jones saw a patient who had been delivered of a child a few weeks previously, the uterus was enlarged. The sound was passed several times and always penetrated several inches, no bad result followed.

Dr. B. B. Browne thought perforation may occur as the result of ruptures during a previous labor.

Dr. Moseley said he thought no one should use the sound without first introducing an easily bent silver probe to ascertain definitely the direction of the canal, as any force required to penetrate a uterus would bend the probe.

Dr. Chunn said where the diagnosis is uncertain between an ovarian cyst and a fibro-cystic tumor without any marked distinguishing symptoms; if the sound, upon being used, pierces to the depth of several inches a fibro-cystic tumor must be diagnosed. In the case of a pregnant woman in whom the fœtal heart could be distinctly heard, the child was afterwards thought to be dead, a sound was introduced which penetrated up to the handle. The patient

died, and an extra uterine pregnancy was found at the autopsy.

Dr. Tiffany exhibited a patient who, years ago, had chronic synovitis, followed by ankylosis. The ham-string tendons were divided, but with no good result. When he was twenty years of age, with an ankylosis of the joint at right angles, the ham-string tendons were divided, but still no good result. An excision of the knee was then done, the bones wired together. A good result followed this last. From want of use the muscles had become atrophied; the leg was shortened about two and a half inches.

Dr. Michael read a paper, it being a report of five cases, showing the use of

HYDROCHLORATE OF COCAINE IN GENITO-URINARY SURGERY.

(See the JOURNAL of Nov. 22d, p. 59.)

The doctor had excised a tonsil upon which the cocaine had been used, but without any effect from the drug. He had done a circumcision; the drug was used with a most excellent result, no pain was experienced when the mucous membrane was cut, and only slight pain when the skin was reached.

Dr. Keyser said that he had seen the muriate of cocaine used by Prof. R. B. Morison at the Baltimore Polyclinic, in a case of lupus vulgaris, which was being treated with the sharp spoon and the scarifier, followed by the application of luna caustic. When first used the cocaine, being applied upon the unbroken skin, was not sufficiently absorbed to show any appreciable anæsthetic effect during the cutting operation, but upon being afterwards applied to the cut surface, just previous to the application of the caustic, it rendered this most painful part of the operation almost painless. Subsequently another portion of the diseased skin was operated on. For some days previous to this second operation the part was washed with tinct. sapo viridis, so as to soften and partially remove the epidermis. A four per cent. solution of cocaine was made use of in the usual way. The operation which followed, although not painless, yet was attended with very much less pain than were former operations on the same patient when the cocaine had not been employed. Towards the circumference of the patch, prepared for operation by softening and removing the epidermis, pain was appreciated, while complete anæsthesia was obtained throughout the area of the patch.

Dr. B. B. Browne had used cocaine in a case of stenosis of the cervix. The drug in solution was well applied, even into the cervical canal and about the cervix; the introduction of the dilators caused no pain, but the dilatation did.

Dr. Theobald had used cocaine in the enucleation of an eye, the cutting of the muscles, and final cutting out of the organ caused some pain. In a case in which the eye was much congested, he had used a two per cent. solution with entire disappearance of the trouble.

Dr. Winslow exhibited a specimen of a

HYDROCEPHALIC BRAIN WITH CALVARIUM.

As soon as the calvarium was removed the brain collapsed and about a pint of water ran out from each side, the ventricles were dilated and corpus callosum ruptured, the convolutions were spread out. She had been a woman of average intelligence, about sixty years of age, good spirits, and had had no untoward symptoms. Her hearing was acute, and eye-sight good. For six months before her death she had had some stomach trouble, and the last few weeks slept most of the time. The doctor also exhibited a large gall stone from the same woman.

Dr. Pole exhibited a large gall stone from a patient now living.

Dr. Chambers cited the case of a man thirty-four years old who had hydrocephalus with few important symptoms. He thought the trouble likely due to the closure of the openings leading from the ventricles.

HALL OF THE BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD NOV. 10TH, 1884.

(*Specially Reported for the Maryland Medical Journal*).

The Association was called to order by the President, Dr. E. G. WATERS.

The Committee of Honor reporting favorably on the name of *Dr. G. S. Shannon*, he was elected to membership.

Dr. Kemp moved that the order of business be changed so as to go into the elec-

tion of Recording and Reporting Secretary. Carried.

Dr. G. Henry Chabot was then elected Recording and Reporting Secretary.

A Case of Fecal Inpaction was reported by Dr. James A. Stewart. The patient was a lady who seemed to be suffering from digestive disorder, later with vomiting. Tried everything, but could not stop vomiting for any length of time; gave calomel, which seemed to operate freely. This went on for about six weeks, patient very much run down in health, when his attention was called to a tumor in the abdomen, which, on examination, proved to be fecal impaction. The mass, when removed, weighed about eight pounds. Twenty-four hours afterwards the patient ceased vomiting and was very much improved. Dr. S. thought there must have been a channel through the mass, as the purgatives had the desired effect. Drs. Rohé, Gibbons, King, and Browne reported similar cases. Dr. Chambers did not think there was a channel through the mass; he thought the discharge was from below the impaction.

Dr. Stewart said the present diarrhœa could not take place from below, as the impaction was too low down, and also, the purgatives could not reach the rectum below the impaction.

Dr. Chambers thought the irritation might set up diarrhœa below the impaction.

Hysteria Simulating Locomotor Ataxia, reported by Dr. James A. Stewart. Was called in to see a lady with all the symptoms of locomotor ataxia. At first she could not play the piano, and fell several times on the street. She got worse, and could not walk at all; the left side worse than right; tongue drawn to one side; sensation nearly normal. Dr. S. consulted with Dr. Miles, who thought it a very peculiar case. She had perfect tendon-reflex. Put her on the usual treatment, electricity, &c.; has improved very much, and is nearly well; general health good.

Dr. Sellman said he knew the patient to be hysterical.

anæsthetics in obstetrical practice.

Dr. Roseberry opened the discussion by a paper, of which the following is a summary of the most important points discussed:

(1.) That in all cases of natural uncomplicated labor where instrumental interference is not needed, anæsthetics are unnecessary.

(2.) That labor is a physiological process, and that the pain is bearable, as it is of short duration, and there are long intervals free from pain.

(3.) That the pain is a valuable guide to the physician, and will often help him to guard against lacerations.

(4.) That it would not be justifiable to run the risk of losing the patient to relieve the pain that she is able to bear. The doctor also related six cases (of a collection of three hundred and ninety-three, reported by Prof. Henry M. Dyman, of Chicago) that died in confinement from anæsthetics.

Dr. Williams had not had any difficulty from anæsthetics; uses them very often; thinks we ought to relieve the pain.

Dr. Sellman thinks it is the manner in which it is given; should be given with a cone, and not so rapidly.

G. Henry Chabot, *Secretary.*

Editorial.

What is the True Function of the Physician?—Under the title "Medicinal and Non-medicinal Therapeutics," Dr. Austin Flint presented to the New York State Medical Association, at its late meeting, a most interesting and important paper, bearing upon this subject. It is written in the inimitably terse and logical style of the author, with which all who are familiar with his writings are well acquainted. The views here presented have appeared before in the author's works, but he elaborates and impresses them here in a style far more calculated to attract notice and interest.

Is the physician a mere prescriber of drugs? Is this the only, or even chief, function which he has to discharge? Such was, and is still, the popular idea. Patients expect to take drugs, they are disappointed if they do not get them, and their gratitude and appreciation of our services are often measured by, if not dependent on them. A visit unaccompanied by a prescription is often considered as of no value. The science of medicine, says Prof. Flint, is identified in the popular mind with the employment of drugs; the fact that one may be an accomplished anatomist, an erudite physiologist, a profound pathologist, and a distinguished

diagnostician, irrespective of extraordinary knowledge or skill in the medicinal treatment of diseases is not appreciated. But the profession know better than this; they know that it is equally important to withhold, as to administer drugs, and that it often requires much greater knowledge and firmness. The attitude of the physician should be rather that of a medical counsellor, whose duty it is to preserve health and prevent no less than to treat disease. This can only be attained by reforming the popular ideas concerning medicine; by discountenancing the idea that drugs are to be employed as a matter of course, by the disuse of placebos, by pointing out the intrinsic tendency of diseases to recovery and the part played by nature, whose servant the physician is, and by inculcating the true value of medical science. Within the profession there must be more unanimity, less blind faith in medicines on the one hand and less sweeping skepticism on the other. In this connection the author impresses the fact that clinical experience is the only reliable basis of therapeutical knowledge.

The subject of non-medicinal therapeutics, including food, alcohol, and especially mental therapeutics, receives full elaboration at the author's hands. We have not time to reproduce comment on all the important subjects of the paper which we commend very strongly to the reader's attention as worthy of the most attentive perusal and study, and as answering very fully and satisfactorily the question with which this article commenced.

Hospital Saturday and Sunday Association.—The Baltimore Hospital Saturday and Sunday Association is about to issue its third annual appeal to the public of this city for aid for our hospitals. We feel sure that it is an object which will commend itself to the community, and it deserves a liberal support. The Association which was founded in imitation of similar ones, inaugurated in Manchester, England, and now in successful operation in most of the large cities of England and some of our own country, has for its object "to draw out benevolent gifts for hospital purposes, by bringing the claims of these charities simultaneously before the public; to stimulate and foster the giving by personal donations and church collections on appointed days on behalf of such institutions as the donor or donors may choose; and to provide a way for obtaining and distributing the gifts of those who sympathize with the general object of hospital charity without being interested in any particular institution." The collections for 1884 will be held on Saturday, Dec. 27th, and Sunday, Dec. 28th; on the former day boxes will be distributed in the business centres, drug stores, and among the various business associations, as the Corn and Flour Exchange, etc., and simultaneously contributions will be sought among the various branches of trade by representative men thereof; also collections will be made in the synagogues. On Sunday the collections will be made in the Protestant churches. It is to be regretted that the Roman Catholics still prefer to hold aloof from participation in it, and that our Archbishop has not seen proper to imitate the example of his brother in the Episcopate, Archbishop Manning, of England, who, if we are correctly informed, has given it there his sanction and warm concurrence.

The receipts last year were not equal to expectations, for, whilst in 1882 (the first year) $2,264.89 was realized, in 1883 they reached but $1,667.52. It is to be hoped that the loss thus shown may be more than made up in the receipts of 1884.

The hospitals now represented in the Association are the Union Protestant Infirmary, Protestant Episcopal Church Home and Infirmary, Presbyterian Eye and Ear Charity Hospital, Baltimore Eye, Ear and Throat Charity Hospital, Nursery and Child's Hospital, Hospital of the Women of Maryland (McCulloh street); Woman's and Child's Hospital (Eutaw street); and the Hebrew Hospital. Each one of these has its representative member in the Association.

The officers of the Association are: President, Judge George Wm. Dobbin; Vice-President, Daniel C. Gilman (President Johns Hopkins University); Secretary, Dr. Eugene F. Cordell; Treasurer, Fred'k M. Colston (of Wilson, Colston & Co., bankers); Executive Committee: Judge Dobbin, Mr. E. Otis Hinkley, Mr. W. W. Spence, and Dr. J. Pembroke Thom.

We will conclude in the language of the first general appeal, with the hope "that this movement, now only municipal, may at no far distant day become national both in England and this country."

Physiological Notes.

"The Physiological Effects of Light which Enters the Eye Through the Sclerotic Coat" has been studied by Prof. Sewall, of Ann Arbor (*Jour. of Physiol.*, Vol. V., No. 3). It has been long known that light thus entering the eye is diffused within it as red light. This exhausts the so-called "red elements," thus making the eye, so illuminated, more sensitive to green. Prof. Sewall suggests that the agreeableness of a spring landscape is due to this cause, and supports his suggestion by the observation that when sclerotic illumination is cut off it no longer has the same effect. He also found that finer discriminations could be made with sclerotic illumination than without it; thus showing that the diffused light within the eye aids vision.

"The Influence of the Nervous System in Rigor Mortis" is the subject of an investigation by A. V. Gendre (*Archiv. f. d. ges. Physiol.*, B. 35). If, in a frog, the ischiatic nerve on one side be cut, immediately after death, while it is left intact on the other, it is found that the leg with the intact nerve is the first to enter rigor. As this difference in time disappears when the central nervous system is destroyed, it is inferred that impulses passing along the efferent nerves are the cause of the phenomena. These results are supported by experiments on animals, and in the case of a hemiplegic individual, it was observed that after death the sound side first entered into rigor.

"The Disturbances of Vision after Injury to the Cerebrum" is the title of a paper by Jacques Loeb, a student working in the laboratory of Galtz, at Strassburg (*Archiv. f. d. ges. Physiol.*, B. 34). He finds that he can remove the cortex from any of the so-called visual centres of Munk, Ferrier and others, without the slightest disturbance of vision, and hence concludes that the visual centres of these authors do not exist. When a disturbance of vision does occur it is always an homonymous lateral hemiamblyopy of the eye on the side opposite the injured hemisphere. This hemiamblyopy occurs, whatever part of the hemisphere is injured. Hence we have here a certain sort of localization, but in no wise corresponding to that demanded by Ferrier and his school. The experiments were entirely on dogs, and whatever the truth of the results may be, the author does not seek to make from them any inferences to man.

Book Notices and Reviews.

On a New Method of Recording the Motions of the Soft Palate. By Harrison Allen, M.D., Prof. of Physiology in the University of Pa. Philadelphia: P. Blakiston, Son & Co., 1884. pp. 24.

This treatise is the most valuable contribution to the physiological study of the movements of the soft palate with which we are acquainted.

When an instrument such as, for example, the loop of a snare, is passed into the nasal pharynx, it frequently happens that, as it passes through the posterior nares over the bulge of the muscular gralate, the contraction of the latter can be felt as it elevates the distant extremity of the wire. This fact, to which we called attention some time ago (*Transactions of the Med. Chir. Faculty of Maryland*, 1883, p. 281), has been observed independently by the author, and has been utilized in a most ingenious way in the construction of a method for recording the movements of the palate.

A delicate rod is passed through the nostril in such a manner that the motions of the palatal muscles shall be imparted to its distal extremity. The portion of the rod which projects from the anterior nares is held in apposition against the anterior border of the nostril by means of a flexible copper wire, the upper end of which is attached to the head band used for the frontal laryngoscopic mirror. When thus adjusted it will be found that the motions of the palate will cause a perceptible deviation of the free end of the rod. The subject to be experimented on is now seated in front of a Ludwig's kymographion, and the tracings of the free end of the nasal rod taken upon its revolving cylinder.

For further particulars concerning the apparatus which the author has called the "palate myograph," for an historical survey of the literature of the subject, and for the results arrived at by means of this simple method, we must commend the perusal of the author's interesting monograph. The palate myograph may be utilized not only for studying the mechanism of the palate in health and disease, but the range of its

application may be extended to the study of phonetics, and, as the author claims, may be made available for the comparative study of languages, the instruction of the deaf, and the construction of a system of logography or short-hand writing. J. N. M.

BOOKS AND PAMPHLETS RECIEVED.

A Practical Treatise on Massage. Its History, Mode of Application, and Effects; Indications and Contra-indications. By DOUGLAS GRAHAM, M.D. New York: Wm. Wood & Co. pp. 286.

A Hand-Book of the Diseases of the Eye and Their Treatment. By HENRY R. SWANZY, A.M., M.B., F.R.C.S.I., Surgeon to the National Eye and Ear Infirmary, Ophthalmic Surgeon to the Adelaide Hospital, Berlin. With Illustrations. New York: D. Appleton & Co. pp. 437.

The Physician's Pocket Day-Book. Designed by C. HENRI LEONARD, M.A., M. D. The Illustrated Medical Journal Co., Detroit, Mich. Price $1.

Miscellany.

SQUIBB ON HOW TO USE NITRITE OF AMYL.—Good glass-stoppered vials of one ounce capacity, the stoppers being ground with extraordinary care, and the ground surfaces being slightly lubricated by a very minute quantity of soft white paraffin, are the best containers of this very difficult liquid; but there is another way of transporting and dispensing it that is well worthy of attention. It is not uncommonly put up and sold in the form of "pearls of nitrite of amyl," minute flattened flasks, the end of which has been sealed in the lamp after the flasks were filled. They vary in size, containing two to ten drops each. Formerly they were made of very thin glass so as to be crushed by the fingers in a handkerchief; but a large proportion of these were lost by spontaneous bursting, which created great dissatisfaction to buyers and a strong prejudice against them. Now, however, they are made of much thicker glass and cannot be broken by the fingers, and the spontaneous bursting is now comparatively rare. But they now require some hard substance to break them. Enclosed in the folds of handkerchief and laid upon a table, a smart blow with a closed pocket-knife is sufficient to break the glass and liberate the contents for use. They are sold by the dozen or by the hundred, as ordered, packed in cotton in pasteboard boxes. One house sells them in boxes of one dozen each, and each box contains what is called a crusher, consisting of two small turned wooden boxes, one inside the other. The inner box holds two or three pearls, and between the bottom of the inside box and the bottom of the outside one is carried another pearl surrounded with a little cotton. This crusher is intended to be carried about the person, and when the effect of the nitrite is needed the lid of the outside box is taken off and the inside box is forced down upon the pearl (a three drop pearl) beneath it, so as to crush it and allow the liquid to be absorbed by the cotton. The inner box is then taken out and the vapor inhaled from the outer box. This is much better than inhaling it from a handkerchief, because the diffusion is so rapid from the latter that it is difficult to get the vapor into the lungs in a sufficiently concentrated state as to get enough of it before it is dissipated. Although very convenient, an objection to the pearls is their comparatively high cost. By far the most economical and perhaps the best way of using the agent is to buy it in an ounce vial, and from this to replenish as often as needed. A very small pocket vial, say a 30 minim one, half filled, strong to avoid breakage, with as large a mouth as possible, with a good cork occasionally renewed. There are very few cases in which a sufficient effect cannot be obtained by smelling at the mouth of the vial with one nostril, the other being closed. Two inspirations from the mouth of a 30 minim vial is sufficient to flush the writer's face and increase the pulse rate 40 beats, and the effects pass off within 1½ minutes, excepting the pulse rate which diminishes less rapidly. A third inspiration ten or fifteen seconds after the two, very considerably increases the effect of the others, both in degree and duration, and gives about all the effect that is needed in a large proportion of cases. From time to time, as the effect becomes weaker, the residue in the pocket vial should be thrown away and a new supply obtained from the ounce vial, which should be kept in a cool, dark place.—*Ephemeris*, Nov., 1884.

SQUIBB ON THERAPEUTICS OF NITRITE OF AMYL. It is almost exclusively used by

inhalation and for a prompt and temporary effect in emergency, and hence the great importance of a good quality and of readiness for instantaneous application. Its prominent effect is to suddenly and temporarily relax or paralyze the muscular coats of arteries, thus suddenly dilating those vessels. This practically diminishes the resistance against which the heart has to act without diminishing the power which, for the time, is applied to the heart. Thus relieved of resistance while the power is continued, the heart beats faster in proportion to the relief, until at a later stage, when, if the nitrite be continued, the power applied to the heart becomes lessened and its rate diminished to the new conditions. In a large proportion of the uses of the nitrite, this second stage is to be avoided as useless if not hurtful; so that when the desired results are not obtained from the full effect suddenly produced by a few inhalations, it is best to withdraw the agent entirely for a short time, and then repeat with an increased dose if desirable. When the administration is of short duration, it is not easy to overdose it, because the effects pass off so very rapidly, and most of the harm which has been done by it seems to have been by continuous administration, so as to intensify the after-stage of general depression. It is simply a powerful disturber of heart and arteries, and through the perturbation caused by it, a sudden supply of blood may be taken from the venous system and thrown into the arteries. It is easy to understand how so profound a disturbance, so suddenly induced, may interrupt and reverse any abnormal condition which is commencing, in which contraction of the capillary arteries has either a primary or secondary agency, *e. g.*: if an epileptic seizure begin by a local anæmia in the nervous centres, it is easy to understand how nitrite of amyl may interrupt and reverse this, and thus prevent the seizure whenever the effect can be induced in time. A superintendent of one of the largest hospitals for the insane in the world, states that since his nurses have been trained to the proper use of nitrite of amyl, his epileptic wards have been revolutionized, and by continued prevention of seizures, the habit of recurrence has been so broken that many a curative effect has been obtained. It is easy also to understand how the cold stage of paroxysmal fevers may be interrupted and abated by the agent, while the cold stage of collapse is not benefitted, but injured by it. So in the heart stasis of one of the fatal forms of chloroform poisoning, if the nitrite can be applied before the cardiac syncope is complete, the diminution of the resistance to the heart's action may, in its feeble condition, enable it to make the few pulsations needed to restore the centres of innervation and thus prevent death. Almost all the cases of pure spasmodic asthma which occur suddenly, and a large proportion of the cases of angina pectoris are relieved by it by a similar rationale, and the amelioration of spasm in tetanus has a similar explanation. There appears to be some relation between the suddenness of the attacks and the usefulness of the remedy; experience showing it is rarely useful in conditions coming on slowly, or relieving for the moment only. Only a few neuralgias, and those spasmodic, appear to be relieved by it for any considerable time.

Excision of Initial Sclerosis in Syphilis.—Pick, of Prague, at International Med. Congress (*Brit. Med. Jour.*), always distinguishes carefully between the cases in which the glands are indurated and the opposite. When the glands are affected they must also be excised, but general symptoms almost always follow notwithstanding. Simple excision of the sclerosis when the glands are affected will never be successful, and no excision avails when the deep glands are swollen. Excision most commonly only causes delay in the appearance, not prevention of general symptoms; but it shows that the indurated sclerosis is not the expression of general syphilis. The lymphatics have recently been found to be much enlarged in such cases, and he believes that the syphilitic poison enters through these and not entirely (Auspitz) though the blood. Unna believed that syphilis spreads by the blood-vessels, by the lymphatics, and by simple contiguity of tissue. Neisser said, although it is uncertain by what path the virus enters the system, still as it is a bacterial disease, there is no theoretical reason why it should not be prevented from entering by timely destruction of the bacteria. Bergh submitted statistics showing the comparative worthlessness of excision as a protective measure. Leloir and Barthélemy adduced cases in which excision a few hours after the ap-

pearance of the initial lesion had failed to prevent infection. Martineau thought the chancre a manifestation of general infection, and that, therefore, it was useless to excise it.—*Lond. Med. Record*, Oct. 15.

Precautions Against Cholera in Factories.—The Medical Department of the Local Government Board, of England, has issued a memorandum to those engaged in factory work, both employers and employés, upon this subject. It insists that the purity of the water supply is the most important thing to be secured, as even the slightest taint in it may be dangerous. All closets should be supplied with separate cisterns, and cisterns from which drinking water is drawn should be frequently cleansed. Any connections of waste-pipes with drains should be severed. If the water be obtained from springs, wells or other private sources, their surroundings should be carefully examined, so that all leakage or filtration from sewers, drains, privies, cesspools or foul ditches in the source of supply, or into the neighboring soil may be stopped. If there be privies, the receptacles should be frequently emptied, and no accumulation of filth should be allowed to exist. No filthy refuse of any kind should be allowed to lie in or near any room, shed or yard, where work-people are employed. Defects due to drainage, by which the air of the work-rooms become fouled with sewer-air, should be corrected. When the disease prevails, employers should encourage their workmen to report to the physician at once any case of bowel trouble that occurs in themselves or in members of their families, and he should keep on hand, for use in such cases, some simple diarrhœa medicine for immediate use, keeping a record of the cases and inquiring for them after some hours.

Varieties of Dyspnœa in Bright's Disease.—Dr. R. P. Howard, of Montreal, read a paper on this subject at the recent meeting of the Canada Medical Association, of which the following were the conclusions: 1. That marked dyspnœa might occur in Bright's disease, not due to gross lesions in heart, lungs or pleura; 2. That it might be (*a*) a continuous dyspnœa, or (*b*) paroxysmal in character, resembling spasmodic asthma; and (*c*) that these types might occur in the same case, but the continued variety was more frequent than the asthmatic; 3. That these forms of dyspnœa might occur as the prominent symptoms of renal disease, and their origin might escape recognition if the urine be not carefully examined; 4. That the Cheyne-Stokes' respiration was often a symptom of Bright's disease, and that it occurred both in the acute and parenchymatous and in the chronic interstitial nephritis; 5. That while the Cheyne-Stokes' breathing was usually an evidence that the fatal issue was near at hand, it might occur in a chronic form, and might recur for weeks, and perhaps even for years; 6. That these several forms of dyspnœa were due to that defective renal elimination called uræmia; 7. That in the acute form of Bright's disease, serious or fatal dyspnœa might sometimes occur in connection with effusion into the submucous membrane of the larynx, so-called œdema glottidis.—*Brit. Med. Journal*, Oct. 18.

Chloride of Ammonium or Muriate of Ammonia is very largely used in medicine, and its use has increased so largely and so steadily during the past ten years, without any special fashion or advertising, that there can be no doubt of its utility or of the definiteness of its effects in general practice. Yet it is one of those remedies which writers find it difficult to classify by its effects. Its most general useful effect is to attenuate or liquify tenacious secretions or deposits, which obstruct surfaces, plug up minute cells and ducts, and thus obstruct and retard the action of the eliminating surfaces and organs of the body. As a typical illustration, its effects upon the bronchial excretions when these become so tenacious as to be very obstructive and very difficult to dislodge; and its effects in removing goitre and other glandular enlargments and obstructions. It appears to cause the dilution and washing away of condensed or semi-liquid deposits by favorably modifying the action of the surfaces and cells involved. It is best administered freely diluted at the time of taking, in ten grain doses, three or four times a day. This dose may be largely increased if necessary. In pharyngeal and bronchial affections, the inhalation of sprayed solutions is often very useful.—*Squibb's Ephemeris*, Nov., 1884.

Cocaine in Laryngeal Phthisis.—Dr. Lefferts, of New York (*Med. News*, Nov.

29), has demonstrated the utility of this agent in a large series of cases in relieving the terrible dysphagia of advanced laryngeal phthisis. He details one case as an illustration where deglutition had been impossible for one week on account of the acute pain which it caused, together with the immediate reflex spasm and rejection of the smallest amount of fluid nourishment in any attempt at swallowing. The patient was slowly perishing from hunger and thirst. One application of the cocaine so blunted the sensibility that a full glass of milk was immediately drunk with ease and entire comfort. Each subsequent application produced the same result, and also notably relieved the dyspnoea. A four per cent. solution was used, the applications being preceded by thorough cleansing of the mucous and ulcerated surfaces of thick, tenacious muco-purulent discharges by the spray solution; the parts were then bathed gently with a large laryngeal brush fully charged with the solution. One application suffices.

Fixation of Movable Kidney by Scratching its Capsule Through the Loin.—*Mr. Greig Smith* (*Lancet*) reports the case of a woman, æt. 35, at the Royal Infirmary, Bristol, who, a year before admission, noticed a tumor in the abdomen on the right side, usually under the ribs, but occasionally low down, near the crest of the ilium. The facility with which this tumor could be pressed down into the pelvis suggested the possibility that it might turn out to be ovarian, and Mr. S. recommended abdominal section to remove it, if not renal, to fix it if renal. This was done, and the tumor turned out to be renal. There was no proper meso-nephroa, and the kidney was found very freely movable. An attempt was made to stitch the organ to the loin, but this failed, and the capsule was well scratched with a needle and placed in the loin. The inflammation thus produced sufficed to keep the kidney in its place, but the patient did not derive any benefit from the operation, although she made a good recovery.

Osler on Infectious Pneumonia.—*Dr. Wm. Osler*, in a paper on pneumonia as an infectious disease, read at the late meeting of the Canadian Medical Association, dwelt especially on the following points (*Brit. Med. Jour.*): 1. The existence of a considerable body of evidence to show that pneumonia occurs sometimes in epidemic form, and infects certain localities, *i. e.*, houses and barracks. 2. The presence of the micrococci in the exudation which has been abundantly proven. It is, however, very doubtful if the encapsuled coccus, described by Friedländer, is peculiar to the disease. 3. The micrococci can be readily cultivated, and when inoculated in mice and guinea-pigs, they die within a variable period, but whether the affection produced is a genuine pneumonia or only septicæmia, is not yet satisfactorily settled.

Prepuce Grafting.—The suggestion is made, in the *Lancet*, October 4, 1884, by Dr. R. Clement Lucas, that the skin removed in the operation of circumcision can be advantageously used for purposes of skin grafting, to fill large granulating surfaces left after burns. Owing to its suppleness, thinness, and vascularity, it seems peculiarly adapted for such purposes. He believes that this skin might be conveyed for some hours, without loss of vascularity, if placed in a glass bottle or wrapped in gutta percha. Of course, we must only use the prepuce from healthy children, and if a balanitis accompanies the phimosis, it must be cured before the circumcision is performed.—*Med. and Surg. Reporter.*

Paracentesis Thoracis as a Therapeutic Agent.—W. Henry White, M.A., M.D., Assistant Physician to the Royal Hospital for diseases of the chest, concludes the leading article on the above subject in the *Brit. Med. Journal*, of Nov. 1, 1884, with the following "recapitulation of the points which are of importance in the treatment."

1. In pleuritic effusion, early evacuation of the fluid is advocated by the syphon principle, discarding the aspirator.

2. In empyema, pus should be withdrawn at once by the syphon or by the aspirator, with the use of the manometer, and the pleural cavity irrigated.

3. Incision is called for where large empyemata have existed for some time in old or rigid chests, or where irrigation, having been practiced several times has failed.

4. Where incision fails to effect a cure, resort must be had to resection of ribs.

5. Paracentesis, with drainage, should be employed in the treatment of lung cavities.

Treatment of Asiatic Cholera.—*Prof. De Giovanni*, of Italy (*Lond. Med. Rec.*, Nov. 15), advises the following treatment in Asiatic cholera. In the prodromal period he advises absolute rest in bed, milk and broth diet, naphthalin or thymol given before food. Naphthalin may be given in doses of 2½—3 grains four or times a day, which may be increased to 30—45 grains a day, if well borne. Copious enemata of boiled water acidulated with 2 p. c. of acid hydrochloric should be given. The action of the skin at the same time is to be encouraged by diaphoretic drinks or wet or dry rubbings. He recommends a mixture of saturated infusion of camomile, ounces vj –ix; camphor grs. xv—xxx dissolved in sufficient rectified spirit; laudanum ♏ xv—xxx; one tablespoonful for a dose.

When the diarrhœal stage has set in, treatment must be symptomatic. 1. Rest must be insisted on and strict diet. 2. Cardiac and vascular excitants, diaphoretics, diuretics should be given. 3. Frequent frictions of the body should be made. 4. A cold bath should be given, even repeated several times in the day, followed by general massage and packing with flannel. 5. Before the skin has lost its power of reaction, large mustard plasters should be applied to the abdomen. 6. If the dejections be very copious, bismuth and Dover's powder should be given. 7. The vomiting may be treated with ice, or if obstinate, with hypodermic injections of morphia. Frictions and packing are means of much therapeutic importance since they not only maintain the surface temperature but exert an exciting reflex action on visceral innervation. The cold stage should not be waited for before using them. If the patient, before the onset of the prodromal symptoms has been constipated, castor oil in moderate doses should be given. If without much diarrhœa and with progressive general prostration, he acquire the well known characteristic color, or especially if there be any trace of jaundice, calomel should be tried. In the algid stage subcutaneous or intravenous injections of saline solutions may be tried. The aim of our treatment should be to succor the general conditions which are threatened in a measure not proportional to the morbid intestinal manifestations and to correct the morbid intestinal function. Of the many bactericides with which experiments have been made in the laboratory some do not admit of their being used in the treatment of the cholera patient and others have been already tried in past epidemics without success. Although no specific is known, he thinks much may be expected from rational symptomatic treatment on the above lines; and that even in the cure of this, the most fatal of all contagious diseases, nothing justifies the skepticism of some practitioners.

Post-Partum Avulsion of Uterus with Recovery. At the meeting the London Obstetrical Society, held Oct. 8th, 1884, *Mr. J. Hopkins Walkers* reported the following case (*Brit. Med. Journal*, Oct. 25): A patient, æt. 22, was in her third confinement with only a midwife in attendance. This person, finding that the placenta did not come away after the birth of the child, pulled at the cord, which broke at its attachment. She then introduced her hand and tore away the whole of the uterus with the right ovary and Fallopian tube, portions of the round ligaments, the left Fallopian tube and the ligament of the left ovary attached to it. Mr. W. saw her twenty-one hours after the accident, and found her under the influence and somewhat recovered from severe collapse. A large quantity of omentum protruded from the vulva, and in the upper part of the vagina was an enormous rent. He ligatured and cut away the omentum, which was cold and badly bruised at the level of the vulva; the parts were washed with solution of permanganate of potash and a pad of salicylated wool was applied. The opiate was continued, catheterisation ordered every eight hours, and the diet limited to milk and beef-tea. She did well until the fifth day, when she was seized with shivering; her temperature fell to 97.4°, and the pulse rose to 170. The vagina was irrigated with permanganate solution, and finding the vaginal fundus well closed around the omental stump, a solution of carbolic acid was afterwards used. Quinine in large and frequent doses was combined with the opiates, and the vagina was syringed every eight hours. On the twenty-eighth day she drove five miles to the hospital; three months after the accident the omental stump had frittered away, and the vaginal wound was perfectly cicatrised. Two and a-half years after the accident the patient was in perfect health

and attending to her ordinary occupatious. Mr. W. had found records of thirty-six cases of accidental removal of the puerperal uterus, fourteen of which recovered.

Mercurial Injections in Syphilis.—Liebreich of Berlin maintained (Proc. of International Medical Congress, *Brit. Med. Journal*), that the conditions requisite in any mercurial compound for subcutaneous use were that it must not precipitate albumen, that it must be indifferent to the connective tissue, that it must not be decomposed by an alkaline solution, and that it must be easily broken up so that with sulphur, sulphide of mercury be precipitated. In the author's opinion, all these conditions were fulfilled by the formamide of mercury, which was easily prepared by precipitating the oride by carbonate of ammonia and dissolving it in formamide. Martineau believed that subcutaneous injection was the only reliable method; he had used it exclusively for the last few years. Neisser thought the formamides were eliminated too quickly. Doutrelepont did not believe formamides to be the best form for injection. Shoemaker, after long experience of various injections, had come back to simple corrosive sublimate solution, in water, as the most effective and least irritating. Wolff, for five years, has used the formamides, using them freshly made from triturated solutions, and they worked quickly and well. Barthélemy always used peptones for injection, and they act quickly; he believed, however, pills were by far the best and simplest method for continued treatment. Kaposi found injections useful, but inunction by far the quickest and most vigorous method of cure.—*Lond. Med. Record*, Oct. 15.

Hydrodimon as an Antipyretic.—*Dr. P. Seifert*, of Dresden, describes this agent as a benzol derivative obtained by adding sulphurous acid to chinon. It crystalizes in rhombic colorless prisms, is little soluble in water, easily so in alcohol and ether, and has a sweetish, not unpleasant taste. The usual dose for an adult is 15½ grs, and its antipyretic action is almost unfailing. The temperature begins to fall within one-quarter hour, with sweating; remains lower for two or three hours, and then rises during the next hour to its former level. Pulse becomes slower, urine darker; respiration is unaffected. Three or four doses a day suffice, in continued fever, to keep the temperature at a moderate level of about 101° F. No disturbing symptoms attend its repetition. In forty patients four suffered with frequent vomiting, necessitating discontinuance of the drug. No symptoms of collapse were ever observed, nor symptoms resembling cinchonism. Slight shivering was observed, while the temperature rose again. It is apparently contraindicated in phthisis with much vomiting. For children (who were equally finally affected) 5 grs. is the dose at two to four years, and 7 grs. above this. Repetition of the dose is attended by no injurious effects on internal organs, and fever may be kept down by it continuously and methodically. It is especially recommended where quinine is not well borne, the taste being acceptable to children as to adults.—*Berliner Klin. Wochenschrift and Lond. Med. Record.*

Dr. Flint's Model Physician.—The practitioner who holds a just medium between the two extremes (the man of unlimited faith and the therapeutic nihilist) has sufficient confidence in medicinal agents, but recognizing that in proportion to their potency they do either harm or good, he must be satisfied that they are clearly indicated before he employs them. He will not prescribe potential drugs at a venture, but only for a clearly defined purpose. He shoots after having taken deliberate aim, and he shoots with the rifle in preference to the shot.gun. He requires competent testimony based on trustworthy experience before subjecting patients to the trial of new remedies. Fully alive to the progress of knowledge in medicinal therapeutics, he holds fast to what is actually known and adopts what is new on satisfactory evidence afforded by his own experience added to that of others. He may make original observations with a view to enlarge the boundaries of our therapeutical knowledge, but his observations are made with due precautions not overlooking his responsibility for the welfare of his patients. His observations have for their sole object the discovery of truth for a beneficial end. He is conservative, but his conservatism is not fogyism. He cultivates and practices medicine as a science, but he never forgets that medicine is a science of which the pervading principle is humanity.

Prevention of Ophthalmia Neonatorum.—One of the greatest blessings which medical art of late has conferred on mankind is the preventive treatment of the blennorrhœa of the eyes of new-born children. In the October number of *The American Journal of the Medical Sciences* Dr. Henry J. Garrigues calls attention to the value of Credé's method of treatment, which in brief consists in washing the outer surface of the eyelids with plain water, separating them slightly and letting a single drop of a two per cent. solution of nitrate of silver fall from a glass-rod on the cornea. No after-treatment is used.

In 1882 Garrigues introduced Credé's treatment into his service at the New York Maternity Hospital, since which time 351 children have been thus treated and not a single one was affected. He makes this application immediately after the cord has has been severed, which is not done before the pulsation in it has ceased. During the subsequent ablution great care is taken that no foreign substance enters the eyes.

The results obtained in lying-in hospitals by this method are so striking that there cannot be any doubt about the advisability, nay, the duty of adopting it in all such institutions.

Influence of Germ Theory on Future Therapeutics.—Let the doctrine be established, as may be expected, that all infectious diseases are parasitical, and let the class of infectious diseases be enlarged, as may also be expected, and the therapeutical problem will be to ascertain by clinical experience a parasiticide for each parasite. Let this be accomplished and therapeutics will have undergone a revolution, the extent of which it is impossible to foresee. It is most inspiriting to think of the lustre to be conferred on medicine, and of the boon to humanity by the ability to control all the essential fevers, together with septicæmia, epidemic cholera, influenza, pertussis, dysentery, and last, but first in relation to rank as a life-destroyer, pulmonary phthisis! Never before could the medicine of the future have appeared more bright and encouraging than at the present outlook.—*Flint.*

Treatment of Catarrh of Respiratory Passages.—In laryngeal catarrh, with tickling cough and dysphagia, and hoarseness. *Dr. Burney Yeo* (*Med. Times and Gazette*) says warm alkaline drinks are very useful to thin the tenacious adhesive mucus which collects about the glottis, as ℞ sodii bicarb., ʒj.; sodii chloride, gr. xviij; spiritus chloroformis, gtt. xxx; aquam anisi ad ℥ vj. S. One ounce every two or three hours in hot water or milk. At the beginning of acute bronchitis nothing relieves the distressing dryness of the membrane like tartar emetic, as ℞ vini antimonii, ʒ iij; liq. morphiæ acetat., ʒ ij., liq. ammon. acetat., ʒ vj; aquæ lauro-cerasi, ℥ ij; syrupi mori, ℥ ss; aquam ad ℥ vj. S. Tablespoonful every two or three hours, but less frequently as relief is obtained. With much fever, a few drops of tinct. of aconite may be added. ℞. Extract. conii maculati, gr. iij (dissolved in rectified spirit); aquæ lauro-cerasi, ♏ xxx; potassii bicarb., gr. viii; aquæ destill., ℥j. S. Use as a spray, inhaling every two hours, To relieve excessive hyperæsthesia with constant tormenting tickling cough.

A Case of Imperforate Rectum in which Lumbar Colotomy was Performed.—Dr. John H. Packard records, in the October number of *The American Journal of the Medical Sciences*, a case of imperforate rectum in which lumbar colotomy was performed with an unsuccessful result. From his experience he is now of the opinion that in cases in which the object is to open the bowel with a view not only to immediate relief, but to the subsequent establishment of the natural passage and closure of that artificially made, inguinal colotomy is the better operation. His preference for the operation in the loin was based upon a belief in its greater safety, as well as upon his familiarity with it as practised upon the adult. But the risk involved in opening the peritoneal cavity, as well as the somewhat greater difficulty of the operation, would seem to be outweighed by the advantage of far readier access to the cul-de-sac forming the terminal part of the gut, and by the better prospect of thus remedying the abnormal condition.

Frerichs on Treatment of Diabetes.—It is not so powerless as is often assumed, for the author has had cases under treatment for ten to eighteen years, and one for twenty years. A proper mental and bodily diet is of the greatest importance, and mus-

cular exercise carefully conducted is most beneficial. Milk was found unfavorable, especially Dorkin's treatment by skimmed milk. Many alkaline waters were found very useful (Carlsbad, Neuenahr, Vichy) when taken at those places. Amongst narcotics opium is important, as it often lessens thirst, urine and sugar, while body-weight increases. As to the experience usually negative of many so-called specifics, lactic acid had no result, and glycerine was harmful. Salicylic acid, salicylate of sodium and iodoform deserve further trial. All weakening influences and cutaneous irritants are to be avoided. *Centralblatt f. d. Med. Wissenschaften.*

Ingrowing Nails.—Pure carbolic acid does better than any other remedy for ingrowing nails. The 95 per cent. acid runs in between the nail and the irritated flesh, and allays the irritation. In every case where it has been used, the *Boston Journal of Chemistry* reports that the pain ceased at once, and immediate recovery ensued.

Medical Items.

An epidemic of hydrophobia is prevailing in Vienna, eighty cases having been reported.

Dr. Henry A. Martin, of Boston, so well known in connection with vaccination, died on the 7th inst.

It is said that the Italian Government has appropriated $20,000,000 for the sanitary improvement of Naples.

Typhoid fever is said to be very prevalent in Philadelphia. It is attributed to the bad water and filthy sewers.

A subscription has been started for the purpose of erecting a monument on the grave of the late Prof. Cohnheim.

During 1883 the six Faculties of Medicine in France conferred 662 diplomas of M.D.; 692 were conferred in Germany during the same period.

Von Bergmann says the enthusiasm about transfusion has died out in Germany, as in England, and the transfusion apparatus lies undisturbed upon the shelf.

The Alumni Association of the University of Maryland offers an annual prize for a successful thesis written by an alumnus. See advertisement in next issue.

Dr. Seaton Norman, of Baltimore, has been appointed a hospital steward in the Marine Hospital service, and will be stationed at Washington, D. C.

A bronze statue of Sir Erasmus Wilson will be erected outside Margate Infirmary. It represents him in the official robes of President of the Royal College of Surgeons.

Dr. Black reports a case (in the *Lancet*), where a needle broke off a year ago in the first joint of the left thumb, and a few days ago it was felt and removed from the right forefinger.

The Berlin University Medical Society have offered a special protest against the appointment of Dr. Schweninger to the Chair of Dermatology, and a resignation of the entire Faculty is hinted at in case their protest is ignored.

Frederick A. Mahomed, M.B, Cantab., F.R.C.P., died November 22d, in London, of typhoid fever, æt. 35. He was Physician to Guy's Hospital, and contributed many valuable papers to Guy's Hospital Reports on chronic renal disease and albuminuria.

Dr. J. Wm. White has been elected a member of the Faculty of the University of Pennsylvania and Director of Physical Education. Dr. Edward T. Bruen has been elected Professor of Physical Diagnosis and Dr. Louis Starr, Clinical Professor of Diseases of Children in the same institution.

Nothing is easier than to prescribe drugs. On the other hand, to refrain from their use may require, in addition to knowledge and judgment, not a little firmness and independence. An ignorant or weak practitioner may be tempted to pursue a medicinal treatment in opposition to his judgment or in order to cover up his lack of knowledge. *Flint.*

Surgeon-General Hamilton, in his annual report of the Marine Hospital Service just submitted to the Secretary of the Treasury, says: Quarantine measures, however efficient, will not alone suffice to prevent an epidemic of cholera in this country should it once pass the outer barriers. Prompt isolation of the first cases and municipal cleanliness are absolutely necessary factors in the prevention of epidemics.

Original Articles.

INORGANIC HEART MURMURS.*

BY CHAS. W. MITCHELL, M.D., OF BALTIMORE.

The frequency with which abnormal heart sounds are heard during life without the autopsy revealing any adequate cause therefor, renders a consideration of the subject perhaps not untimely.

The attention of clinicians was called to these murmurs shortly after the introduction of auscultation by Laennec, and as they were generally looked upon as being due to changes in the physical character of the blood, they were designated "hæmic" murmurs. Probably a more fitting term is "inorganic", as including all murmurs which cannot be accounted for by the gross examination of the heart after death.

Difficulty in the explanation of these sounds arises from the fact that we are, as yet, somewhat in the dark as to the precise causation of the normal heart sounds. The most recent investigations, however, particularly those of Ludwig, lead us to the conclusion that the sounds are made up of two factors, a muscular and a valvular element. The third factor, the impulse of the heart against the chest wall, has been shown to be of so little importance that it may be disregarded.

These inorganic murmurs are frequently met with in anæmia and chlorosis. They are particularly marked in leucocythemia. They occur in chronic malaria, tuberculosis, and that form of Bright's disease in which we find the large white kidney. Then, too, these are frequently heard in the course of the acute infectious diseases, such as typhus and typhoid fever, small-pox, pneumonia, and diphtheria.

Bartholow speaks of the occurrence of heart murmurs in acute rheumatism, without the existence of cardiac disease.

The belief of modern clinicians, that failure of the heart's action constitutes the greatest element of danger in acute infectious diseases, has a substantial basis in the fact that that organ so soon suffers when there is general constitutional disturbance. Loomis has well emphasized this fact in his writings upon acute lobar pneumonia.

Almost all diseases then, acute or chronic, which are attended by great malnutrition, may give rise to these so-called anæmic murmurs.

These murmurs have certain definite characters. They are always systolic, never diastolic. They are of a soft blowing nature. Their intensity varies greatly, keeping pace with the general condition of the individual; and they disappear altogether upon complete return to health. They are heard at the pulmonary ostium and in the mitral region, and very frequently about midway between these two areas, that is at a point a little to the left of the sternum, about on the level of the fourth rib.

Ludwig has shown by experiments upon the bloodless heart, that the contraction of the ventricles, although not a muscular tetanus in the ordinary sense of the term, is always attended by a certain tone, and that the character of the sound depends largely upon the state of the heart muscle as regards its nutrition. Recent observations, also carried on in Ludwig's laboratory, lead us to the conclusion that the contraction of the circular fibres around the auriculo-ventricular orifices is an aid in the prevention of regurgitation during the systole.

Now, what is the condition of the heart muscle in the diseases giving rise to these murmurs? Evidently one of mal-nutrition. In ordinary anæmia the biceps becomes softer and more flabby, its contraction less vigorous. So, too, with the cardiac muscle. The tone produced by the systole under such circumstances must differ from the normal. Post-mortem examinations in infectious diseases frequently show the heart to be in a state of cloudy swelling or even of fatty degeneration. Perls, by oft-repeated venesection, produced fatty degeneration of the heart. The integrity of the cardiac muscle may, however, be very seriously impaired before these changes occur. Of course a murmur arising from advanced fatty degeneration cannot be called inorganic, but it must be remembered that this change is among the very latest of the retrogressive processes affecting the heart, and that a muscle apparently in a normal condition may, to a great extent, have lost its contractile power. Then, too, fatty degeneration may make its appearance in little areas here and there, which are so small as to be overlooked, but not too small to seriously impair the vigor and co-ordination of

* Read before the Clinical Society of Maryland, Dec. 5th, 1884.

the cardiac contractions. Tarnier, some years ago, called attention to the fact that the organs of women dying shortly after delivery, show great tendency to fatty degeneration. The so-called anæmic murmurs are heard frequently in pregnant and puerperal women. Certainly we seem justified in concluding that in the very earliest of the changes which ultimately result in the destruction of the muscular fibres, we may have so great an impairment of the contractile power of the heart that the tone resulting from that of the systole is altered in character. A more or less weakened heart then is a potent factor in the production of the murmurs under consideration.

The other element in the production of the normal heart sounds, is the valvular. Any alteration in the tension of the valves is bound to be accompanied by a change in the sound produced by their action. Can such alteration be induced by deficient nutrition of the heart? The tension of the auriculo-ventricular valves is maintained by the circular fibres around the orifices, and by the musculi papillares. Now it is well-known that the last named muscles suffer very early in the course of degenerative changes affecting the heart, and owing to their weakened or incoördinated contraction the tension of the valve is so altered as to produce a murmur. Examples of murmurs produced by incoördination of these muscles are often met with in chorea, in cases in which there has been no antecedent rheumatism, and in which the most careful examination gives no evidence of organic cardiac disease. The systolic murmer often heard in pulmonary emphysema, and at times mistaken for mitral regurgitation, is probably produced by relaxation of the circular fibres around the right auriculo-ventricular orifice, so that regurgitation occurs. Indeed, it is believed by many physiologists that a slight regurgitation always occurs at this orifice. That mere dilatation of the left cavities of the heart can ever give rise to regurgitation is, to say the least, very doubtful.

The cardiac endothelium also is also apt to suffer under circumstances giving rise to inorganic murmurs, and such changes as a very slight roughening of the endocardium may be factors in the production of the abnormal sounds.

To Conheim belongs the great credit of having been the first to insist upon the pathological significance of changes in the blood-vessel walls. Before his day, undue prominence was given to alterations in the blood itself. Thus, in the old theories of blood-clotting, the cause was sought in the blood, independently of the vessels containing it, and it is only recently that the so-called restraining influence of the healthy endothelium has been recognized. So, too, it was thought that the watery elements of the blood could ooze through healthy vessels, giving rise to hydræmic dropsy; and that by weak action of the heart alone thrombosis could occur, as in the marantic thrombosis of Virchow. Cohnheim, however, proved, experimentally, that neither of these processes could occur so long as the vessel-wall remained perfectly healthy. It was under the influence of the old teachings that inorganic murmurs were explained in all cases by the supposed watery conditions of the blood; and the fact that a badly nourished muscle performs its work badly was entirely overlooked. Here, as in the process just mentioned, undue stress was laid upon slight changes in the specific gravity of the blood.

If these murmurs depend upon watery blood, why are they never diastolic? They are only heard when the heart muscle is contracting. The fact that they are heard most frequently at a point widway between the valves seems also to point to a muscular origin. Skoda, who, perhaps, did more than all others to establish auscultation and and percussion on a purely physical basis, states that a mere watery condition of the blood cannot account for these murmurs. Just as we at present search the vessel walls for the cause of thrombosis, instead of calling upon increased coagulability of the blood to help us out, let us, in the matter of abnormal sounds of the heart, search the walls of that organ, which is morphologically a blood-vessel, and which, in nearly every case, when its muscular and endothelial elements are carefully examined, will give us an anatomical reason for the occurrence of the murmurs.

These murmurs being met with under a great variety of circumstances, the recognition of their true nature becomes a matter of importance. Much harm has been done by basing the diagnosis and prognosis upon the murmurs alone, which should be looked upon as indicative rather of the general state of bodily nutrition than of

any special condition of the heart. Inorganic murmurs may coexist with valvular disease.

It is well known that in persons suffering with valvular lesions, the existing murmurs are always intensified when the nutrition of the body is depraved, and became less marked as the general health improves.

An individual may become anæmic, suffer from shortness of breath, have some palpitation, may even have slight hydræmic dropsy. The practitioner hearing a systolic murmur, attributes it to mitral regurgitation or pulmonary stenosis, and regards the dropsy and general anæmia as due to the valvular lesion. The patient leaves the doctor, much depressed by the gloomy prognosis. He puts himself, however, under favorable hygienic circumstances, his appetite returns, his muscles, heart included, become braced up, and his systolic murmur gradually disappears, much to the surprise of his medical attendant. Nearly every physician has met with cases in which people have been rejected for life insurance, and thus caused much anxiety and unhappiness, merely on account of these inorganic murmurs. Flint, some two years ago, published a valuable paper in the *New York Med. Record*, in which he called attention to the great care which is to be exercised in the prognosis of all cardiac diseases, and to the necessity of considering the general condition of the patient in estimating the extent of the heart lesion.

Errors in diagnosis most frequently arise from undue prominence given the murmur. Bamberger says that no diagnosis can be made from a systolic murmur alone, however loud it be. Auscultation is too often the only means of examination of the heart. Palpation, percussion and inspection are essential in every case in which an accurate diagnosis is to be made. There are some murmurs, such as the aortic regurgitant, which of itself may inform us of the condition of a certain valve, aucultation alone can never reveal to us the condition of the heart. Yet, in many cases, particularly if the patient be an American woman, auscultation is the only method of examination employed, and that, too, with two or three layers of clothing between the ear of the auscultator and the chest of the patient. Under such circumstances a better diagnosis and prognosis can be made by simply sitting down, and carefully looking at the patient, and leaving the heart alone altogether. Let us, in all examinations of the heart, remember that every murmur does not mean valvular disease, and that unless we find unmistakable evidence of secondary changes in the heart and other organs, such as hypertrophy, dilatation, visceral congestion, marked abnormalities of the pulse, etc., the murmur is almost certainly of inorganic origin.

DOUBLE INGUINAL HERNIA IN A MALE INFANT THIRTY-EIGHT DAYS OLD—STRANGULATION ON THE LEFT SIDE —HERNIOTOMY.*

BY L. W. STEINBACH, M.D.

Adjunct Professor of Anatomy and Surgery in the Philadelphia Polyclinic.

The subject of my remarks, a male infant, was born on September 2d, of the present year, at the beginning of the ninth month, of utero-gestation. During six weeks preceding labor the mother was confined to her bed or room on account of hemorrhages, due to partial placenta prævia. The infant was feeble and bore evidence of premature birth by its general debility, rather than by any specific sign of incomplete development. I estimated its weight at about five pounds. Within two days the child became jaundiced, but his condition otherwise, as well as that of the mother, was sufficiently favorable for me to cease paying regular visits after the tenth day.

On the morning of October 11, the father called and requested me to see the child, because it had been unusually restless during the night, and because the mother had noticed a swelling in the groin the previous evening.

Thinking that this swelling, as described to me by the father, might be a rupture, I visited the child without delay, and on rapid inspection, found a deeply jaundiced little patient, not markedly increased in size since birth, with a tumor in each in-

*Read before the Philadelphia County Medical Society, November 19, 1884.

guinal region, so that the pubic region resembled a mons veneris, with the adipose tissue well developed. As this, however, was not likely to be the case in so poorly nourished an infant, I continued my examination by manual palpation, and felt on each side a firm swelling, which reached up to the respective external inguinal ring, and extended obliquely downwards and inwards into the scrotum to the extent of more than two inches. The tumors were hard, and only slightly elastic, but in neither one could I locate the testicle or separate it from the rest of the tumor.

It will appear that the diagnosis must have been easily arrived at, because there are but few pathological conditions likely to be found in an infant that would resemble this, other than hernia, or perhaps hydrocele. Yet, fearing to exert pressure upon such tender structures in order to satisfactorily outline the testicles, I entertained some doubt whether I was really dealing with a case of double inguinal hernia, for which there existed the speculative causes of congenital debility, a patulous canal, and above these an impediment to the easy evacuation of the bladder in the existence of phymosis.

I informed the parents that I believed the child to be suffering with a double hernia, and that I would make an attempt to reduce it.

The amount of manipulation which I considered to be safe, not having lessened the size of either tumor, and there being no urgent symptoms, I left, with the promise to return towards evening of the same day, with instructions to the mother to note carefully whether the child urinated, or had a fecal evacuation. At my evening visit I learned that the child had had no passage since the preceding day, that it passed but a small amount of urine, and was disinclined to nurse. I now renewed my attempts at reduction, and succeeded in returning the protrusion on the right side into the abdominal cavity, the testicle remaining in the scrotum. Only at this juncture did I become positive of my diagnosis. My exertions to reduce the tumor on the left side proved unavailing. In order to ascertain whether I could induce an evacuation of the bowels without endangering the child's condition, I inserted a small cone of soap into the rectum; this met with prompt response from that organ, and together with the soap a small amount of inspissated mucus, intermixed with, or rather discolored by, fecal matter, was expelled. This convinced me that a constriction existed somewhere in the intestinal tract. Placing a small compress over the right external inguinal ring, and securing it by a bandage, in order, if possible, to prevent a recurrence of hernia on that side, by straining in the act of micturition, I left my patient.

In the morning, and again towards evening of the following day, attempts made at taxis were unsuccessful. Constipation, scanty urination and refusal to take the breast continued until the third day, when I consulted with Dr. John B. Roberts, who concurred in the diagnosis of strangulated hernia.

After some manipulation, which somewhat reduced the tumor in size, and seemed to relieve the symptoms, it was agreed to postpone operative procedure until more urgently required. Towards evening of the same day, the vomiting, which had existed before, became more pronounced, and the copiously-emitted substance, in its consistency, color and odor, resembled fecal matter.

About noon of October 14, and therefore the fifth day after the symptoms of hernia were first noticed, and when the child was just six weeks old, an anæsthetic (ether) was administered; and the last, but unsuccessful attempt at reduction having been made, I proceeded, with the material aid of Drs. Roberts, O'Hara, and other gentlemen, to perform herniotomy.

Making an extensive incision through the tegumentary structures and subsequently dividing two additional layers of investment to the hernia, a sac was reached which was hard to the touch and distended by fluid contents. A puncture of this sac and evacuation of its sero-sanguinolent contents by means of a hypodermic syringe caused its partial collapse, and a trial was made to return the protrusion into the abdominal cavity. This attempt proving ineffectual, the hernial sac was incised. This laid open to view a coil of small intestine of a purplish red hue, and below it the testicle and the epididymis. This last peritoneal investment was the tunica vaginalis testis, and consequently formed the true hernial sac.

Even now an obstacle to the return of

the intestine presented itself at the constricted neck of the sac. The tender age of the patient and the delicate and small structures involved, necessitated the employment of the ophthalmic surgeon's canaliculus knife, in place of a Cooper's hernia bistoury, whilst a small grooved director served the purpose of a hernia director, until an incision enlarged the opening to a sufficient extent to permit of the insertion of Levis' hernia director. The hernia was of the oblique variety, and after extensive enlargement of the external inguinal ring over Levis's director, the intestine was returned into the abdominal cavity.

The interrupted wire suture was now employed, and the first and second stitches penetrating all structures from without into the abdominal cavity, approximated the edges of the external abdominal ring. A strip of rubber tubing was inserted, to favor drainage. The loss of blood was insignificant in amount. Antiseptic precautions were obsorved, by using a solution of corrosive sublimate for the hands, sponges and towels, whilst the instruments were kept immersed in carbolized water. An existing phymosis, which was regarded a factor in the production of the hernia, was corrected at the same time.

A few hours after the operation, the child had a normal passage; the urine which was voided contained a dark green sediment, which remained as stains on the napkin. The child took the breast readily, and appeared in no way to be disturbed by the operation. Primary union took place throughout the extent of the wound, and the drainage-tube was removed on the third day, after which the small orifice thus left also closed. No symptoms of peritonitis, or inflammation elsewhere, appeared; the pulse was better than before the herniotomy; the excretions continued regular, and everything gave promise of a favorable result except that the babe did not gain strength, and the jaundice became rather more pronounced. On the fifth day after the operation, the child died, and I have good reason to believe the cause of death lay elsewhere than in the herniæ.

Not the rarity of the affection induces me to present this case to your attention, but rather my belief in the propriety of performing the operation even in so young an infant. I am not conversant with the literature of the the subject, and do not know whether a few or many cases are recorded, but my observations of this one case causes me to make the deduction that the operation should be performed unhesitatingly whenever indications for it exist; and I believe that the more rapid reparative process existing in infancy gives an even more favorable prognosis than the same operation performed on the adult.

HYDROCHLORATE OF COCAINE.

OBSERVATIONS AND CONCLUSIONS FROM ITS USE.

BY DR. CHARLES A. OLIVER,

Ophthalmic and Aural Surgeon to St. Mary's Hospital, Philadelphia.

With varying quantities of three to eight drops of a two per cent. solution instilled into healthy eyes twice or three times, at five minute intervals, the following observations were made:

1. Almost *ad maximum* pupillary dila tation occurred in forty-five minutes to an hour, the pupil returning to normal size in four to six hours. This length of time could not be considered as normal, as it merely represents the individual muscular *tonus* and amount of endosmosis.

2. During the time of dilatation, the pupillary rim of the iris assumed various irregularities in outline of the same character as may be seen in the action of Duboisia and Homatropine upon the iris.

3. At the time of instillation, no more local inconvenience or pain was complained of than during the use of the solution of the neutral salts of the other mydriatics.

4. In some instances, in a few moments following the use of the drug, there was a complaint of a saltish taste, which quickly passed away.

5. In no instance was there the least con stitutional manifestation of the drug.

6. In every case, accommodative range was lessened, but to what extent, no accurate determination had been made. This came on during the pupillary dilatation, and fully returned in several hours' time.

7. In each case, there was both local analgesia and anæsthesia, Sensation of pain was lost wherever the drug had touched, and sensibility was deadened in localized areas. These evidenced by the

pinching of the conjunctiva with forceps without causing any pain; whilst in some places the grasp was not felt at all, that is, when care was taken not to exert a dragging over a large area of conjunctiva.

Conclusions:

First. Upon account of the evanescence of pupillary dilatation and the quick return of ciliary power, the drug will be of great value in making ophthalmoscopic examinations in cases dependent upon their use.

Second. It will be useful in cases where it is desired to introduce instruments of holding or fixation beneath the lids. Lachrymal probes coated with ointments containing the drug may be of advantage in lessening the sensibility of the passages during the maintenance of the probe in position. In fact, it may be used where any instrument of precision or of treatment is apt to cause error, inconvenience or harm by pain or sensibility.

Third. It may be of value in annulling the pain from applications of cauterizing agents, strong astringents, etc., although it is to be remembered that the tissues may be rendered momentarily abnormal by the anæsthetic to such an extent as to prevent proper actions of the astringent or cauterizing material.

Fourth. In diseases or injuries of the external eye, where nerves are exposed or irritated, it may be employed with much soothing benefit. Thus, in scratches of the corneal epithelium or of the conjunctiva, in superficial ulcerations or nerve irritations, it may be of inestimable good.

Fifth. It may be of value in various surgical operations upon those parts of the eye which can be readily reached by the drug, such as the extraction of foreign bodies from the cornea and conjunctiva, slitting of canaliculi, extirpation of corneal or con junctival tumors, etc.

Sixth. It may be of service as a local hæmastatic in cases of operation where it is desired to follow the steps of the procedure without obstruction from clots and masses of blood, or as a remedial agent in arresting hæmorrhage from trauma or disease.

Seventh. Judging from its action upon the iris and ciliary muscle, it may be of some importance in operations upon these structures in lessening pain and checking hæmorrhage.

Eighth. By its use in ophthalmic surgery all of the petty annoyances from general anæsthesia may be done away with.

Ninth. In view of the powerful effect of the drug upon the eye, more data are necessary before it can be *universally* employed as a local anæsthetic in eye surgery.

Lecture.

THE CARE OF THE VOICE.

HOW THE VOCAL MECHANISM WORKS AND THE PRACTICES WHICH IMPAIR IT.

Abstract of a Lecture Delivered at the Peabody Institute, Baltimore, Dec 4. 1884, by JOHN N. MACKENZIE, M. D., of Baltimore.

Dr. Mackenzie first explained the anatomy and physiology of the structures concerned in the production and modification of vocal sounds, the conditions of proper vocalization and the mechanism of the different registers, as revealed by the laryngoscope. Special stress was laid upon the physiological relations of the air-current in respiration, upon the importance of the "abdominal method" of breathing, upon the evils resulting from "clavicular" and "lateral" respiration, and upon the common causes of vocal fatigue from antagonism of the respiratory forces, abuse of intensity, faulty methods of cultivation, etc. All good teachers compel a preliminary training in vocal and respiratory gymnastics. The old Italian school required two years of such exercise before allowing pupils to sing. Well-trained vocalists rarely suffer from disease of the vocal organs, and the systematic use of the latter is a valuable agent in the prevention of serious pulmonary complaints. Congestion and inflammation of the larynx, loss of contractile power in its muscles, granular pharyngitis and a host of other affections of the throat are often the common heritage of a pernicious method of breathing. Unnatural forcing of the voice, immoderate laughter, the habit of whispering indulged in so often by members of the church choirs, produce fatigue and derangement of the vocal organs from abuse of the intensity of the voice. A singer should never hum, and much resonance is lost by singing through the teeth. Voice-training should be begun, if possible, in youth, for as the

individual advances in life the difficulties of vocal education materially increase. In singing and public speaking a slight artificial congestion of the vocal organs occurs, which subsides with the cessation of the exercise. If sufficient rest be therefore not allowed after such exercise, or if the larynx be exposed to a sudden change of temperature, this congestion becomes permanent. The artists of the dramatic and lyric stage should not themselves be stirred by the passions it is their duty to portray.

The nose was next considered as an organ of respiration and voice-formation, and as the channel through which atmospheric air enters the organ of hearing. Natural respiration takes place through the nasal cavities, in which the air is warmed, moistened and freed of impurities. In mouth-breathing the cold, dry and vitiated atmosphere comes in contact with the delicate lining membrane of the respiratory tract and produces, sooner or later, inflammation. The majority of cases of disease of the vocal organs and ear arise from interference with the functions of the nasal cavities and nasal throat. Catarrhal inflammation of these regions develops insidiously, and is fraught with disastrous consequences to the organs of voice, respiration and hearing. The injurious effects of nasal obstruction and mouth-breathing were formerly known only to experts, who sold the knowledge of the hygiene fact to professional singers for large sums of money and under a pledge of secrecy, and a distinguished scientist has voiced its importance when he exclaims that could he leave a perpetual legacy to mankind he would embody it in the words "Keep your mouth shut."

The importance of attention to the skin as a preventive against disease of the vocal organs cannot be overestimated, and we may possibly indulge the fancy that the invulnerability of Achilles after immersion in the Styx is a warning myth to impress upon mankind the prophylactic virtues of cold water. Compression of the chest and neck impede the proper mechanism of the throat. "The ambitious collar of the dude, which arises from the surface of the collar-bone to be inserted under the lobule of the ear, and whose apparent use is to suspend all motion about the neck," was instanced as illustrative of the latter mode of compression. The use of cosmetics containing injurious metallic oxides and the dyes employed to color certain articles of wearing apparel sometimes exert a prejudical influence on the mucous lining of the respiratory apparatus; the additional ornamental advantage derived from the substitution for the plain white stocking of our ancestors of the variegated hose of to-day, is often insufficient to compensate for the evils which result from the exchange.

The idea that prevails in certain quarters that removal of enlarged tonsils has an evil effect upon the resonance of the voice was declared to be a stupid popular fallacy, diametrically opposed to reason and the facts in the case; for it has been demonstrated that the operation not only renders the voice clearer and more sonorous, but may even allow extension of its compass several notes higher. It had even been maintained that the tonsils do not exist in the normal throat—that they are simply pathological excrescences—and a recent writer had said that were he, like Frankenstein, to attempt the construction of a man, he would leave the tonsils out. Patti, Lucca and other great singers have not only submitted to the operation, but owe the full power of their voices to its performance.

Society Reports.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD DECEMBER 4TH, 1884.

The President, R. A. Cleemann, M.D., in the Chair.

AN OVARIAN TUMOR.

Dr. Drysdale presented a polycystic ovarian tumor which he had removed that morning. He had first seen the patient with Dr. C. R. Prall, May 5th, 1884. She was a married lady, 50 years of age, pale, thin and delicate-looking. She had had eight children, the youngest of which was then sixteen years old. With some trifling exceptions, her menstruation had been perfectly natural until two months' before, since then she had had a constant, and sometimes profuse, discharge of blood from

the vagina, which still continued. She first discovered the tumor in March,1884.

On examination, Dr. Drysdale found a semi-solid, smooth-walled, globular tumor, occupying the lower part of the abdomen and reaching nearly to the umbilicus. It was freely movable, did not fluctuate, but was elastic and a little tender to pressure. Vaginal examination revealed a lacerated cervix. The sound entered the uterus two and a half inches, taking a direction to the right of the tumor. On deep pressure, the end of the sound could be felt at the lower part of the right border of the mass. While the sound was in the uterus the tumor could be moved freely, without affecting it. Dr. Drysdale diagnosticated a multilocular ovarian tumor.

By the 5th of June, one month later, it reached nearly to the ensiform cartilage. From this time it increased rapidly in size, and when it was removed, filled the abdomen, pressing the lower ribs outwards. It proved to be a multilocular tumor of the left ovary.

His object in bringing it before the Society was to obtain an opinion from the members as to the cause of a phenomenon which was observed in the early stage of the growth. When the patient first noticed the enlargement, she found that when she would lie on her right side, the tumor, as if lighter than the surrounding parts would ascend to the left, and when on her left side, would rise to the right. She informed Dr. Prall of this, and he naturally supposed she was mistaken, but a careful examination of the tumor while she changed her position verified her assertion. As the mass increased in size, this peculiar change of position ceased, and when the abdomen was opened nothing could be found to account for the irregular behaviour of the growth.

Dr. Parvin inquired about the length of the pedicle and the weight of the tumor.

Dr. DaCosta has a case under observation in which the condition of great mobility is present.

Dr. Drysdale replied that the pedicle was extremely short. The tumor weighed thirty-five pounds and was multilocular in character. At the time of its removal he could not determine any fluctuation. Every parovarian cyst is movable in its early stages. He intended to call attention to the peculiar, and, to him, unaccountable motion of this particular cyst.

Dr. Chas. Meigs Wilson presented the histories of three cases in which the HYDROCHLORATE OF COCAINE had been used with the hope of obtaining local analgesia, and reported negative results.

MALIGNANT CYSTIC DISEASE OF OVARIES.

Dr. D. Longaker exhibited the specimens with the following history: The subject from whom this specimen was removed was a German woman, sixty-three years old. She had been married the last twenty-seven years of her life, and was sterile. During the last five months she was under the care of Dr. Jas. S. Gibb, of this city, at whose request I first saw her and by whose kindness I am enabled to report the case. The menopause was established at fifty-three, ten years ago. The patient had always enjoyed fair health, but four years ago she again began to have a bloody discharge from the vagina. For this she consulted a doctor, and was soon well again. The date of the onset of her last illness was indefinite. It was insidious, and the particular symptom for which she desired relief was inability to micturate; this was found to be due to suppression of the secretion of urine, as the bladder was empty. There was also decided interference with nutrition. Her appetite and strength failed rapidly. The urine was found to contain a very small amount of albumen. She had occasional nausea, and bilious vomiting and diarrhœa. She suffered with pain in the left side of the abdomen. On examination, the doctor discovered a hard tumor, nodulated, to the left of the uterus, projecting upwards into the left inguinal region; it was adherent and but slightly movable. She was first seen by me on October 6th. At this time she was in bed; suffered from orthopnœa, and was unable to rest or lie down. Her abdominal cavity was greatly distended by a fluid which had accumulated rapidly in the previous three or four weeks. Œdema of the ankles had been noticed a few days before. Her general appearance was decidedly anæmic and cachectic. The abdomen was very tender to palpation, especially over the left inguinal and hypogastric regions. The flanks were bulging and were flat on percussion. The tumor could be indistinctly outlined, immobile, lying in

contact with the left ilium, dipping down into the true pelvis behind and to the left of the uterus and distinct from it. The cervix had undergone senile absorption, but from the os externum a small polyp was found hanging in the vagina. October 7th she was tapped, a large bucketful of brownish-red fluid, of specific gravity 1020, was removed. On microscopic examination it was found to contain blood and various corpuscles and epithelium. The ovarian cell was not found. It contained paralbumin.

A more careful examination now revealed a circumscribed, clearly defined, firm, nodulated growth in the region already indicated. It was found adherent, and could be only slightly displaced. It was of the size of a large fist. Palliative treatment was continued, but the patient's condition gradually grew worse. There was again a slight accumulation of fluid in the abdominal cavity. She was subject to attacks of bilious vomiting and diarrhœa, alternated with constipation. There was no apparent increase in the size of the tumor, and during this period pain was not a marked symptom. At no time was there acute suffering. She died of exhaustion, November 27th. *Autopsy* on the next day, by Dr. Gibb, in the presence of and assisted by Dr. E. W. Holmes and myself. The subcutaneous fat had been almost entirely absorbed. The parietal peritoneum was covered with lymph, with numerous nodular elevations in various stages of organization. The intestines had contracted numerous adhesions. The capsule of the liver was one-eighth inch thick. In the mesentery there were also deposits of lymph, some of which were more recent and less organized. The abdominal cavity contained about two quarts of fluid, the same as that already described.

On the left side, extending two inches above the pelvic brim, was found a tumor, apparently solid, but which, on close examination, was found to be cystic. One of the largest of the cysts had ruptured, the opening was found at the posterior-inferior portion of the growth. It was not recent. The capacity of the emptied cyst was about four ounces. The tumor dipped down into the true pelvis, between the broad and utero-sacral ligaments of the left side. It was very adherent, and was removed with great difficulty. On incising and freely opening the cyst, some coagulated fibrin was found, the remains of a hemorrhage into the cavity. When it was entirely removed it was found to arise from the left ovary. The oviduct was slightly dilated and its fimbriated extremity was adherent to, and spread out over the tumor.

On the right tide, in the broad ligament, there is a cyst slightly larger than the tumor; its contents are dark and very dense. It is very heavy. The cyst is surrounded by a dilated Fallopian tube containing a clear, transparent fluid of a bluish white hue. At its widest part it is an inch in diameter. Behind and below this cyst is found the right ovary, it is adherent, flattened out and seems continuous with it. The entire specimen was carefully dissected out as it is shown. From its rapidly fatal tendency with the macroscopic appearance of the tumor there is very little doubt that a microscopic examination will reveal it to be malignant. Though, perhaps, possessing the greater pathological interest, there are also a few points in the case which may concern us in regard to diagnosis and treatment. Study of the fluid at first caused a suspicion that it came from a cyst, its high specific gravity and the chemical tests to which it answered favored such a view. But this was entirely at variance with the history of rapid accumulation and absence of physical signs indicating the existence of a large cyst. It was apparent at the autopsy that an attempt at extirpation could only have hastened the fatal result. The specimen was referred to a committee for further investigation.

HALL OF THE BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD NOV. 24TH, 1884.

(*Specially Reported for the Maryland Medical Journal*).

The Association was called to order at 8.45 P. M., the first Vice-President, Dr. J. T. Smith, in the Chair; Dr. G. Henry Chabot, Secretary.

There were sixteen members present. Drs. S. T. Earle, Linden avenue and Mosher street; Geo. Thomas, No. 129 W. Biddle street; and J. T. Specknell, S. E. corner Green and Mulberry streets, were unanimously elected members of the Association

THE MEDICAL AND LEGAL DEFINITION OF INSANITY.

This subject was opened by *Dr. A. B. Arnold*, with a paper. He said that the attempts to construct a scientific definition of insanity will necessarily be difficult as long as its morbid anatomy remains undetermined. Strickly speaking insanity, like pain, is only a symptom, and none of the numerous definitions of insanity can stand the ordeal of a severe criticism. All the medical definitions of insanity are too narrow, or the ambiguity and vagueness of the language in which they are expressed render them useless. The legal definitions by the courts have analogous shortcomings. An eminent judge of the English bench hit the nail on the head, when, in a recent murder case, in which the plea of insanity was set up by the defence, he declared that the test of unsound mind rested on the answer to the question: "Could the prisoner help it?" This really contains the whole gist of the matter, for the very incapacity due to a morbid state of the mind to resist new impulses, or the abeyance or absence of the normal mental influences which control and regulate the will, constitute features of insanity. It is certainly of immense importance to the security of society that an undue latitude should not be allowed to the meaning of the term insanity. As the natural result of the alarm which the easy mode of acquitting criminals on the plea of insanity, an extreme reaction now seems to be setting in. This was exemplified a few weeks ago in the case of Reed, in Pennsylvania, who murdered his wife without any apparent motive; although he came from a family saturated with insanity, yet the jury returned a verdict of murder in the first degree. A motion for a new trial has been denied, and the date of execution fixed. The rulings of our courts are calculated to suppress rather than to bring out important facts tending to settle the question of the sanity of the accused. Juries can hardly overcome the suspicion that experts who are engaged and paid by the interested parties are biased. In conclusion, he cited the definition proposed by Dr. Bucknell, as it appeared to him to be acceptable both from a medical and legal point of view. "Insanity is incapability, weakness or derangement of the mind caused by disease."

Dr. Conrad agreed with Dr. A., and thought insane persons know right from wrong.

Dr. Gundry said there was no good definition. Can the person help it, or are they incapacitated by disease? The law is very bad in Maryland, and leaves the jury to blindly judge for itself. Experts will always differ, because the hypothetical points are put differently by opposing lawyers, and this accounts for the difference in their answers.

Dr. Arnold thought that in the jury's mind experts are somewhat biased, because they are paid by opposing counsel. He thought if we had a proper definition we would not have so much trouble.

Dr. Conrad thought we ought to have a definition on which the doctors and lawyers can agree. Insane persons have fear only for the present power; the law is a contingent power, therefore they have no fear of the law.

The discussion was then closed, and, on motion, the Association adjourned.

Editorial.

Resection of the Spinal Column.—One after another the different organs and regions of the body have been invaded by the surgeon until it almost seems as if no portion of the human frame is to be held sacred from operative procedures. The brain, lungs, liver, stomach, kidneys, and intestines have all been required to pay tribute to the advancing science of surgery; but very few surgeons have been bold enough to attack the diseases and injuries of the spinal column with saw or chisel. In recent times, however, the spine itself has in a few cases been subjected to surgical operations of one or another kind. In the *Weiner Medizinische Presse*, of Oct. 19th, 1884, a case of partial resection of the vertebral column is reported by Dr. C. Maydl, of Vienna, which presents many points of extreme interest.

A carpenter, twenty-six years of age, whilst employed building a bridge, was caught by a heavy iron chain and carried into an excavation upon the edge of which he had been standing; the upper portion of the body being held in such a manner that the knees touched the breast. He was

unable to stand subsequently, and from that time until he was admitted to hospital, a period of fifteen months, he was unable to leave his bed. No wound was discovered, but for six months his urine was always passed through the catheter. Subsequently incontinence of urine and feces set in. From the time of injury he experienced no sensation whatever in his legs, nor could any voluntary motions be imparted to them. Subsequently painful clonic spasms of the inferior extremities supervened, which also gradually ceased. When admitted into the clinic, the legs lay parallel and stretched out, the feet in the equinus position, the muscles atrophied. The spinous processes of ninth dorsal to third lumbar vertebræ were tender upon pressure. The tenth dorsal spinous process was unduly prominent when the patient sat up, and its distance was three times as far from the vertebra above as from that below. A slight prominence was seen in the space between the ninth and tenth vertebræ, which was sensitive when pressed upon. No sensation was felt below a horizontal line, one inch below the navel, in front and behind; he was completely anæsthetic from a point $3\frac{1}{3}$ inches below the prominent process. The reflexes could be easily excited, and were very active; upon sticking a needle deeply into the muscles of the leg, the knee and hip-joints would be completely flexed. Upon the utmost efforts being made to move a leg, only the very slightest movement of the left big toe could be executed. Upon the application of the induced current in a strong stream, an active and prompt contraction of the affected muscles occurred. Catarrh of the bladder added to his misfortunes, but under the thymol injections it was recovered from. From the fact that a strong induced current produced muscular reaction, Dr. Maydl concluded there was not a complete degeneration of that portion of the cord below the injury; and bearing in mind the miserable existence of a paraplegic, he conceived the idea of resecting the vertebral arches in order to ascertain the cause and seat of injury, and if possible to relieve it. Perhaps, he thought, there might be a partial compression of the medulla by a fragment, and after the release of the pressure a gradual restoration of function might be gained; more probably, however, was the cord totally crushed, and it was impossible to tell in advance the extent of the destroyed portion. A further idea now occupied the attention of Dr. Maydl, to wit: that if there was only a linear compression of the cord, he would excise the destroyed zone and unite the two portions with sutures. To our mind this is one of the most daring preconceptions which has ever entered the mind of man, and, as far as our reading goes, it is original with Dr. Maydl. "The proof of the pudding is in the eating," and so Dr. M. proceeded to experiment upon dogs. He divided the spinal cord of a number of dogs, and in some cases excised a few millimeters of the cord itself, and introduced sutures through the duramater into the marrow, bringing the fresh surfaces into accurate apposition. Several of these animals survived the operation and gradually regained the functions of the injured part. After further experiments upon the cadaver, Dr. M. proceeded to operate on Dec. 29th, 1882. The patient was placed upon the abdomen and an incision made over the ninth, tenth, and eleventh spinous processes. Incising the fascia on each side, the arch of the tenth dorsal vertebra was exposed, and the superior articular process of the tenth was found placed behind the inferior articular process of the ninth vertebra; also a fracture of the bodies of the vertebræ and a bilateral luxation between the ninth and tenth. A portion of the arch of the tenth vertebra was now removed with chisel and hammer, and a quite severe venous bleeding occurred, which was arrested by compression with sponges. After incising the dura mater only a slight atrophy of the cord was noticed, but pressing upon this or raising it with blunt hooks caused energetic spasms of the muscles of the leg and pelvis. Upon chiselling away the arches above and below the tenth, during which a quantity of cephalorachidian fluid escaped, the cord was found to be extremely atrophied for a space of $2\frac{1}{3}$ inches from the pressure of a sharp transverse band, extending from the ninth to tenth vertebra. This ridge of bone was cut away in order to lessen pressure on the medulla, which was itself too extensively injured to allow of resection and suture. The wound was drained and dressed antiseptically, and healed in due time without fever or other untoward symptoms, except considerable pain at the seat of operation. No benefit resulted from

the operation, and in a letter dated Sept. 19th, 1884, the patient says he is no worse than previously, but also no better.

We make an abstract of this paper by Dr. Maydl both on account of the rarity of operations upon the spinal column, as well as to show that surgeons are already considering the propriety of extending the domain of surgical art to include diseases and injuries of this vital region. In our very humble opinion the doctor made a mistake in subjecting a man who, for fifteen months, had been completely paraplegic to a serious surgical procedure. It was scarcely credible that a spinal cord pressed upon and atrophied for so long a period could regain its functions. There is, however, undoubtedly a future for surgery of the spine. It is possible that in some cases spinal caries may be scraped out in the same manner as is done when other bones are affected. In the *Berliner Klinische Wochenschrift*, 1882, p. 146, Dr. James Israel records the history of a case in which he removed half of the dorsal vertebra with the sharp spoon. The patient had suffered since youth with scoliosis, and subsequently a limited caries of the body of the twelfth vertebra occurred. A spinal abscess became apparent near the first lumbar, and upon incising this it was found to lead to the carious vertebra above and into the spinal canal. All the carious tissue was scooped out and the canal freely opened, when the cord was seen to be compressed and atrophied. The patient did well; there was no reaction; the hectic condition which had been previously present ceased immediately, the wound filled up satisfactorily and had almost healed, when, in the fifth week after operation, increased cough set in and he succumbed to empyema on the thirty-seventh day, the disease having resulted from caries of the twelfth rib. In this case also was paraplegia present, which was not benefitted by the operation. In addition to these operations, a few similar cases have been reported in England, unless our memory is at fault. Whilst these surgical efforts were not crowned with success, they at least show that the spinal canal may be opened under suitable precautions without very great danger, and that portions of vertebræ may be safely removed.

A New National Board of Health Proposed.—At the National Conference of State Boards of Health, held in Washington according to announcement, on the 11th inst., a bill was framed for presentation to Congress during the present session, which provides for the creation of a National Board of Health upon what may be called the representative plan. It will consist of one member from every State Health Board, but excludes entirely the army, navy and hospital marine service, which cannot of course claim to represent any particular sections of the country. Its functions are stated in the proposed bill to be "to frame regulations for the government of the quarantine service, to be vested with exclusive authority for protection of the public health, and upon direction of the President, to be empowered to act independently in the several States, and make and enforce therein its own rules regardless of the local boards."

If the substance of the bill be correctly reported in the above words, it seems to us to fail to meet the needs of the country as to our national sanitary interests or otherwise to commend itself to our reason and judgment. A body formed in the manner proposed would be large and unwieldy. The elements would be scattered far and wide, over a territory thousands of miles in extent, and could, with difficulty, be gotten together for consultation or action. Its members would have their own duties to perform in their restricted fields, and they could not give up the necessary time and attention to the National Body without neglect of the interests of their own States. In many cases they would be unable, for the reasons stated, to attend the meetings of the National Board, and would therefore have to discharge the functions devolving upon them in connection with the latter by proxy or to shift them altogether upon the shoulders of their colleagues. It would almost certainly become necessary to have an Executive Committee with large discretionary powers of action. Such a bill would fail to secure the hearty co-operation of the navy and other services which would be so essential to its successful working; indeed it would probably invite from the beginning their hostility and ill-will. Some of our best sanitarians are connected with these services, and why should not the country have the benefit of their abilities and acquirements?

While, therefore, we are open to conviction upon satisfactory reasoning, it appears

to us, on the above testimony, that the proposed bill will not meet the occasion or our pressing needs—pressing, more especially, in view of the near approach of the season when we may expect the arrival of the cholera germ in our midst. If we were permitted to express an opinion on the subject we would advance the view that the National Board of Health should be an integral part of the Government; that it should be composed of a very small number of expert sanitarians, who should reside in Washington, and that this body should have liberal appropriations of money and large discretionary powers, and not too much bossing from superiors ignorant of sanitary science but with extravagant ideas of their attainments in this field.

Manufacture of Cocaine.—The difficulties connected with the manufacture of the new anæsthetic, cocaine, would seem to be very great if we may judge by the experience of Dr. E. R. Squibb, the well-known chemist and pharmacist of Brooklyn, as detailed in his *Ephemeris* for November. This gentleman, who is probably as skillful as any one in his profession in this country, employed about a month of his time and over one hundred pounds of the best coca leaves which the New York market would afford, "with almost negative results." All the accessible published processes were tried and also some original ones; some of these "yielded no alkaloid at all, others only traces, while others gave a few grains which had to be used up in the testings to ascertain their identity." An assay of the leaves employed showed that they contained about .18 p. c. of cocaine, the usual proportion being about .2 p. c. Before the present excitement began, the cocaine in our market has always come from abroad, Merck, of Darmstadt, being the principal manufacturer. As soon as the demand became known orders were therefore sent abroad for supplies of it, but only a small quantity has been received in reply, probably because of an equally great demand abroad also. The price of the muriate of cocaine (Merck's) before the excitement was sixteen cents per grain; the price of the same article is now five to six times as great. Dr. Squibb considers that it cannot be successfully and permanently manufactured in this country, chiefly because of the enormous tax on alcohol and ether here. In Germany the expense is much less. Dr. Squibb suggests the oleate of cocaine as the most eligible preparation for use on the skin on account of its facility of absorption. Since Dr. S's attempts were made two American houses have announced that they were prepared to supply a 4 p. c. solution of their own manufacture; they are McKesson & Robbins, of New York, and Parke, Davis & Co., of Detroit. We learn also that Mr. Emich, of this city (Baltimore), succeeded in extracting fourteen grains of the salt from a pound of the leaves. Dr. Squibb utters this warning for those professing to manufacture it. That "something like an alkaloid is always obtained by all the processes, but it often proves to contain very little or no cocaine." In this connection we may advert to the very great and immediate relief experienced by a druggist of this city in a severe injury to his toe nail, from the local application of the fluid extract, and suggest the use of this preparation to our readers.

Book Notices and Reviews.

Henke's Atlas of Surgical Anatomy, A Series of Plates Illustrating the Application of Anatomy to Medicine and Surgery, Translated and Edited by W. A. Rothacker, M.D., Pathologist to Cincinnati Hospital, etc., Cincinnati. A. E. Wilde & Co., Publishers.

This American reproduction of Henke's Atlas of Topographical Anatomy will prove to be a most valuable help to students and practitioners. It is a clear, plain exposition of applied anatomy for every-day use, and cannot fail to serve a useful purpose as a work for general study or for handy reference. The work is handsomely printed and bound, and apart from its usefulness as a supplement to any Text-book of Anatomy, will be an ornament to the physician's library.

Dr. John Charles Faget, an eminent Creole physician of New Orleans, died Dec. 7, æt. 75. He was Chevalier of the French Legion of Honor, and author of several works on yellow fever and kindred diseases.

Miscellany.

Gonorrhœal Rheumatism.—M. Terrillon, lecturing at La Charité, observed that by a curious chance he had two patients in his wards suffering in a very similar manner from this somewhat rare affection. They were both young men who had been for a few weeks the subjects of subacute gonorrhœa, when they were seized with severe inguinal pain with fever and *embarras gastrique*, one of the patients feeling considerable pain and tenderness on pressure in the vicinity of the hip-joint, while in both the movements of the joint were somewhat impeded, and in both there was a deep-seated doughy resistance in the inguinal region. The conclusion arrived at was that the bursa situated beneath the psoas was the seat of pain, but this continued for some time rather obscure. This rheumatic affection is not merely a coincidence of the gonorrhœa, but a form of rheumatism which developes itself without any other cause whatever than the gonorrhœa. It is indeed not rare to meet with patients who, having been cured of a first attack of rheumatism occurring under these circumstances, do not suffer from subsequent attacks unless they contract a second blenorrhagia. This form of rheumatism has its peculiarities, for it attacks females very seldom, and nearly confines its attacks to the large joints—the hip, knee, and elbow; the smaller joints only suffering secondarily. Moreover, it is generally mono-articular. Sometimes it is attended with effusion into the joints, while at others it gives rise to anchylosis in even ten or fifteen days, the rapid formation of fibrous adhesions rendering this incurable. This rheumatism may, however, affect other parts than the joints. Thus (1), what seems to be an articular affection may really be one affecting the neighboring tendinous sheaths, a tendinous synovitis with swelling and effusion. (2) It may invade the muscular system, the muscles of the neck, the deltoid, or even the motor muscles of the eye being affected. (3) It may manifest itself in the serous bursæ, near the joints, as the hip, patella, or elbow. (4) It may attack the sciatic nerve, and this is not very rare. (5) M. Guyon first pointed out a doughy state of the cellular tissue that may occur, accompanied by pain and heat. (6) Many examples exist of its attacking various tissues at once in the same region. Gonorrhœal rheumatism, moreover, is peculiar in not giving rise to any visceral phenomena, so that affections of the chest do not result from it. It is also fugaceous and does not reappear, except after a new gonorrhœa. The relation between it and the discharge is somewhat curious, for in some patients who had had abundant discharge, this diminishes as soon as the rheumatism is manifested; but this is not constantly the case. As to its prognosis, the disease may be said to be of but slight importance when it attacks only the tendinous sheaths, the bursæ, and the muscles; but this is far from being the case when a joint is invaded, for so liable is it for anchylosis to take place, that our first object should be to place the limb in the most favorable position in case this should occur. Even when anchylosis does not occur, stiffness of the joint is one of the most common sequences, and this, accompanied as it often is by muscular atrophy, is long in disappearing. In these cases we must allow the joint to gradually resume its movements and not endeavor to force this by violent measures, under pain of finding the fibrous tracks increase in number and thickness. This state of atrophy and stiffness is much benefitted by electrical currents, by *massage*, by sulphurous douches, and by a course of mineral waters at Aix. The treatment of gonorrhœal rheumatism is not the same as that of ordinary rheumatism in which salicylic acid is the heroic remedy. Here it is of no avail, and we have to content ourselves with revulsives, chiefly blisters, repeated as many as three times at intervals of two or three days. When the effusion is abundant we should not hesitate to puncture the joint, which is an excellent proceeding, relieving it at once of a mass of liquid which would require at least two or three weeks for its absorption. After the puncture effectual compression should be applied. Finally, the disease leading to a considerable depression of strength in the course of a few days, its subjects should be carefully "tonified" and the tonic *par excellence* in such a case is the sulphate of quinine.—*Gazette des Hopitaux*, Aug. 7.

Dr. Lombe Atthill on Intra-Uterine Medications. — Dr. Atthill terminates a paper on this subject in the *British Medical Journal* of Nov. 29th, with the

following conclusions, the result, he says, of a very extended experience in the use of the various agents recommended in the treatment of cases requiring intra-urine medication:

1. Carbolic acid in the proportion of one part of spirit to two of the acid is the safest and most generally useful of all the agents employed.

2. Carbolic acid should always be applied by means of a probe around the point of which a layer of cotton is rolled, the cotton being carried up to the fundus at least twice on each occasion that the applications are made, which should be on every third or fourth day, till marked improvement takes place.

3. Carbolic acid should never be injected into the uterus except when combined with iodine in the form known as iodized phenol.

4. In many cases iodized phenol may, with advantage, be applied by means of a probe.

5. In cases in which metrorrhagia or profuse menstruation occurs, depending on an unhealthy condition of the intra-uterine mucous membrane, the cavity being dilated and the uterus enlarged, from half a drachm to a drachm of iodized phenol may be injected with great advantage.

6. In cases in which epithelioma attacks the mucous membrane of the cavity the injection of iodized phenol promises better results than any other treatment.

7. The success likely to follow the injection of iodized phenol renders the dilatation of the uterus, the use of the curette, and the subsequent application of fuming nitric acid, less frequently necessary than has been the case hitherto.

8. The injection of iodized phenol requires to be carried out with so much care that it should never be injected except by means of a syringe which will not contain more than one drachm.

9. The use of the fuming nitric acid should be limited, as a rule, to those cases in which dilatation has been practiced, and it should always be applied through a tube inserted into the cervix uteri for the purpose of protecting the sides of that canal from the action of the acid.

10. The pain produced by the application of any medicinal agent to the intra-uterine cavity does not bear any relation to the activity of that agent, but is due to one of two causes, either to hyperæsthesia or to narrowness of the cervical canal, especially of the os internum.

Foreign Bodies in the Eye.—Dr. Agnew, of New York, writes:* "When a patient comes to you complaing of a sensation as if a foreign body were in the eye, you should first examine the eyeball from every point of view. You should then turn over the eyelids and examine their inner surfaces. And here I am reminded of a source of error to which I would call your attention. A few days ago a case came under my observation which illustrates the point. The gentleman had had occasional attacks of conjunctivitis for a year or more. He had then a sensation as if a foreign body were in the eye. On turning out the right lower eyelid, all that was revealed to sight was a slight redness of the conjunctiva. But there was something in the way in which the sensation of a foreign body in the eye was exaggerated that made me suspect he had a single inverted eyelash. Ordinarily he felt as if some irritant was there which was tolerable, but suddenly there would be a cramp-like action of the eye-lid, the irritation would grow rapidly worse, and the eye would fill with tears, followed by the discharge of a little mucus, and temporary relief. His beard was of a sandy color, his hair was light brown, and his eyelashes were almost colorless. I looked very carefully along the edges of the lids in search of inverted eyelashes, and saw, on the innermost edge of the lower lid, a slight curving of the inner angle. By allowing a tear to gather upon this inner edge, I saw that there was a difference in refraction in different portions of the tear, and it soon became evident that a delicate decolorized eyelash was there, which, instead of growing from the outer edge of the lid, sprang from the free edge of its inner border. I turned the lid over, and found that this delicate eyelash, which was between the edge of the lid and the eyeball, had been so long caught in that position that it had worn a little groove in the edge of the eyelid; the spasmodic action of the orbicularis, from time to time, so long continued, had embedded the eyelash in the substance of the lid. I removed it, and no further trouble was experienced. This patient had

* American Practitioner, May, 1884.

been treated in Europe for acute conjunctivitis several times, and it is possible that the eyelash was, on those occasions, the cause of all the trouble. An operation will be required to destroy the follicle which produced the misplaced eyelash. So when a patient comes to you complaining of a sensation as though there were a foreign body in the eye, between the eyelids and the eyeball, you must first look for conjunc tivitis. Whether this be present or not, you should then proceed to examine the eye very carefully to see whether a foreign body be present or not. Scan carefully the whole surface of the cornea and of the scarlet conjunctiva, and then turn over the upper eyelids and carefully inspect its inner surface. You may then scrutinize the edges of the lids, as I have described, in order to see whether the source of the irritation be an inverted eyelash."

Dr. Geo. Johnson on Picric Acid as a Test for Albuminous Urine.—Picric acid as a test for albuminous urine is more free from fallacy than any other, not even excepting heat and nitric acid; of course in a doubtful case no one would neglect to apply more than one test. That picric acid is a more sensitive test than heat and nitric acid is easily proven by taking a highly albuminous specimen and gradually diluting it up to the point where, though these tests fail to detect it, picric acid still gives a distinct reaction. The main advantages of picric acid as a test for albumen are the following: It instantly detects a small amount of albumen which nitric acid would indicate only slowly or not at all; while, on the other hand, an insufficient addition of the test does not, as is the case with nitric acid, prevent the subsequent coagulation by heat; neither, on the other hand, does an excess of picric acid redissolve the precipitate as does an excess of nitric acid. For bedside urinary testing the portability of the innocuous powder is a great convenience. The fact that with caustic potash it is an infallible qualitative and quantitative test for sugar, may be said to more than double its value as an urinary test.

A Contribution to the Clinical Study of Rötheln or German Measles.—It appears to be a somewhat general opinion that Rötheln, or, as it is not infrequently called, German measles, is a disease of such minor importance as to be unworthy of scientific research; but a disease, the victims of which succumb as early as the fourth day, must be of sufficient importance to demand our attention and the best efforts of our armamentarium.

Dr. W. A. Edwards, during the winter and spring of 1881–2, studied in the Philadelphia Hospital over one hundred cases of the disease, and the results of his observation he details in a valuable clinical paper in the October Number of *The American Journal of the Medical Sciences.*

As regards the diagnosis, he says the eruption appearing on the third day first in the face, its rapid extension, its gradual shading off into the surrounding skin, its elevation, more particularly in the centre of the patch, which is also the brightest in color, together with the fact that desquamation first shows itself there, are all points which, as far as the eruption is concerned, render the diagnosis plain; furthermore, the rash almost at once occupied the whole body, and never presented a crescentic outline.

Radical Cure of Hernia by Torsion of the Sac.—In the *Brit Med. Journal*, of September 19th, W. C. B. Ball claims the following advantages for twisting the sac in operating for the radical cure of hernia. 1. There is a more thorough closure of that portion of the sac situated in the inguinal canal than can be obtained by any simple ligature, no matter how high up it is placed. 2. The twisting has the effect of tightening and throwing into ridges the peritoneum for a considerable area surrounding the abdominal opening. 3. The danger of septic peritonitis is diminished. The author's experience is, as yet, small, but he urges other surgeons to give this operation a trial, so that by reliable statistics, comparisons may be made between this and other methods of operation.

A Case of Resection of the Pylorus for Carcinoma.–In the October issue of *The American Journal of the Medical Sciences*, Dr. Randolph Winslow, of Baltimore, reports, with full details, an unsuccessful case of pylorectomy performed with antiseptic precautions upon a woman aged 42, suffering from carcinoma, who, in her own words, was "dying every day." She survived the operation two hours.

False Albuminuria.—In a paper on this subject, read before the New York State Medical Association (*Med. News*), Dr. Gasper Griswold, of New York, said this false albuminuria included two distinct classes of cases: (1) those in which the urine does not contain albumen, but a precipitate resembling albumen is noticed under ordinary tests, and (2) those in which albumen is present in the urine, but does not come from the kidney. A small quantity of albumen in the urine was often of greater importance than a large amount, since there was no difficulty in those cases of Bright's disease in which there was marked albuminuria, which was usually accompanied with extensive dropsical effusion. It was of great moment, therefore, to decide whether a slight cloud discovered under careful testing was really albumen or not. In this paper Dr. Griswold said he would confine himself to the ordinary tests of heat and nitric acid; but it must be understood that the test-tubes employed should be absolutely clean, that the urine should be carefully filtered, and that the testing should be made in a suitable light, with the tube held against a black background. He then proceeded to speak of the substances in the urine which were likely to give precipitates resembling albumen, and the mode of detecting them.

(1) *Phosphates.* Here the heat-test and cold nitric acid test would answer.

(2) *Mucus.* This did not usually interfere with the examination for albumen; but there are two exceptions: (*a*) when the mucus was alkaline, and (*b*) when it was in such excess that a slight cloud of albumen could not be observed. In the first condition the cold nitric acid test would answer, and in the second the mucus could be removed by adding liquor potassæ and filtering; when the cold nitric acid test could be employed as before.

(3) *Uric acid.* In this case the urine was to be diluted.

(4) *Peptones.* True peptones were not precipitated, but hemipeptones were precipitated by cold nitric acid.

(5) *Resinous drugs, like copaiba.* Here alcohol could be used to dissolve the resinous precipitate.

When albumen was present in the urine, but did not come from the kidney, it was due to one of the following substances: (1) *Blood.* To be detected by the microscope. In some instances only albumen and coloring matter remained; the corpuscles no longer existing. Here the test for hæmoglobin was to be applied. (2) Pus. (3) Prostatic or spermatic fluid.

Case of the Restoration of the Natural Color of Human Hair after Having been Grey for Several Years.—Dr. Vandeleur C. Isdell, L.R.C.S.I., L.M., Dub., reports the following case in the *London Med. Times*: "In conversation with Dr. George Harley, F.R.S., of London (during his homeward voyage from attending the recent meeting of the British Association in Canada), regarding the changes in color which occasionally take place in human hair, I mentioned a curious circumstance in connection with the restoration of color with which I am intimately acquainted, from its having occurred in the case of my own father, Dr. James Isdell, of Dublin.

The main features of the case are the following:—

In the year 1861, when at the age of 62, both the hair of his head and beard was completely grey, whereas, in 1882, that is to say 22 years later, when he died at the age of 83, the hair of his head was of its original natural dark color, the whole of it being quite dark with the single exception of a few grey hairs on each temple.

Unfortunately, as regards the condition of the beard at the time of his death I can say nothing, from his having shaved it off many years previously, and never allowed it to grow again.

I may mention that my father had been a teetotaller for upwards of 40 years, and that his mode of life had always been an exceedingly regular one. Moreover, no constitutional or other reason, that I am aware of, could be assigned for this strange freak of Nature in restoring to its natural color my father's hair after it had become decidedly grey, and it is on account of authentic cases of this unusual occurrence being exceedingly rare, that, at Dr. George Harley's suggestion, I send you this brief history of the case as I think it may be useful to persons collecting data in connection with the anomalies of hair coloration."

Introduction and Extraction of Needles.—M. Després, in a lecture which he delivered at La Charité (*Gazette Médicale*,

May 17), made some interesting observations. A young woman striking a table with the palm of her hand thrust a needle into the base of her middle finger, and this, striking against the first phalanx, broke and became fixed there. When seen two days afterwards, the fragment of needle had completely disappeared amidst the inflamed tissues. On pressing at the base of the middle finger, however, a foreign body, pressure on which occasioned pain, could be felt. An incision was made at this point, and a fragment of needle, measuring 1½ centimetre, removed by the forceps. Here the incision was justified by the fact that the foreign body was firmly fixed. The subject of a second case was a young woman into whose breast a needle was driven obliquely by a blow, and entirely disappeared under the skin. Guided by the patient, the presence of the needle could be ascertained; but in this case an incision for its removal would be improper, for the integuments of the breast are so mobile that an incision made in the skin would not correspond to the foreign body. The presence of the needle having been exactly determined, we should seize it in its length and make pressure on its two ends. At one of these we may perceive a slight cracking sound, and here the patient also feels a sharper pain than elsewhere, and this is the point of the needle. If we now press firmly upon the other end, this point will be forced through the integument, and can then be seized with a forceps. An incision should never be made except when the body is fixed in the tissues, as in the first case. One caution must be borne in mind, and that is, we should never attempt an extraction on the mere statement of the patient that a needle is present in the tissues, and when we are unable to verify its presence; for sometimes persons declare that they have needles in their tissues when they have not; or when we are consulted the needle may have already migrated to another part of the body, this migration sometimes taking place very rapidly.—*Med. and Surg. Reporter.*

Venesection in the Convulsions of Pregnant and Parturient Women.—In a paper on this subject, read before the New York State Medical Association, Nov. 19th, the author, Dr. Darwin Colvin, stated that in an experience extending through forty years he had never had a fatal case from eclampsia. He believed that if venesection was reverted to before the patient had sunk into a profound comatose condition, recovery would follow in every case. In concluding his paper, he laid down the following rules for the avoidance of convulsions: (1) Always examine your patient at least two months before the expected confinement, if possible. (2) Test the urine from time to time during the intervening period. (3) If there is much cephalalgia, whether there is albuminuria or not, practice venesection. (4) Warn the patient against indulging in food that is likely to bring on acute indigestion. (5) Keep the bowels in a soluble condition. (6) If at the beginning of labor much headache is present, practice venesection, and if the suffering continues, give a hypodermic injection of a quarter of a grain of morphia.

Surgical Operations Upon the Pregnant Woman.—A discussion arose in the Paris Surgical Society upon the propriety of performing severe surgical operations upon the pregnant woman (*Gaz. Heb.*, No. 30.)

M. Larger asked the advice of the Society upon the following case: A pregnant woman, aged 27, has a tumor of the left breast. This, which before pregnancy was the size of a small egg, has now attained that of a man's head. It is a very vascular encephaloid, but not adherent nor as yet involving the lymphatics.

M. Palaillin described a similar case; a woman six months pregnant had mammary cancer. She was anæsthetized and the growth removed; the wound healed kindly and parturition took place normally and recovery therefrom was without complications. The cancer, however, returned one year later.

M. Terrilon:—A woman in the fifth month of pregnancy suffered fracture of the fore-arm with rupture of the radial artery. She was half an hour under chloroform during the surgical treatment, but no bad results ensued.

M. Verneuil thought that operation demanded by such accidents as hemorrhage, strangulated hernia, or tracheotomy, should be practiced without hesitation during pregnancy. The patient of M. Larger attacked by a cancer that must continue to increase, should be operated upon. Strict

antisepsis should be applied and open dressing, to diminish as much as possible the chances of traumatic fever.—*Courier of Medicine.*

A Peculiar Case of Infection.—That iodoform does not destroy the poison of the soft chancre, may be inferred from the following case, which Dr. E. Lesser, of Leipsic, reported in the *Viertelsjahrsch. f. Dermat. u. Syph.*, 1, 2, 1884:

In consequence of a cut, a young girl had a small wound on the anterior surface of the right forearm. To try the rapid healing generally induced by iodoform, some of it in powder form was brushed over the wound with a camel's-hair brush, which as was later discovered, had been used on the previous day on a patient suffering from soft chancre. Two days later the wound of the girl had changed to a deep ulcer of the size of a pea, and its appearance as well as further progress completely harmonized with those of a soft chancre.

L. remarked that he cannot say for certain that iodoform does not destroy the virus of the soft chancre. as he does not know how intimately the iodoform had been mixed with the discharge from the sore. The case teaches us to be careful with those of our instruments, may they be brushes, probangs, scissors, knives, or anything else, which we employ in cases of specific ulcerations. It would be safer if physicians would keep a special set of instruments for cases of syphilis, and it is only remarkable that not oftener an infection is caused in such a manner. Regarding lunar caustic, which, perhaps, of all things used in a physician's office, is the one most likely to be promiscuously employed, it has never yet been determined whether the specific virus, where in contact with the virus, is effectually destroyed or not, though we may presume that it is.—*Med. and Surg. Reporter.*

Gonorrhœa and Chordee.—Troublesome gonorrhœal cases do not fail to occur except in the experience of those who are in the possession of unfailing remedies. A retired army surgeon, without apparently expecting such good results, ordered for an officer, some fifteen years ago, who was just about to present himself for duty, but who was suffering from gonorrhœa associated with an intense chordee at night, the following two preparations: aquæ, ℥ vij., mucilago acaciæ, ℥ j., ext. belladonnæ, gr. xx., and zinci sulph., gr. xx. A teaspoonful injected frequently. The other is an external application consisting of unguenti spermaceti ʒ iv., unguenti hydrarg., ʒ iv., ext. belladonnæ, gr. x., ext. opii, gr. x., to be smeared freely along the perineum and around the crura penis at night. "Complete cure" occurred within a week. The following injection for gonorrhœa is also recommended. It is claimed to be superior to any other single injection: ℞. Pulv. iodoform, 20; acidi carbolici, 10; glycerini, 80; aquæ destillatæ, 200.—*Med. Record.*

Iodoform in the Treatment of Tuberculosis.—Dr. R. S. Smith, in a letter to the *Brit. Med. Journal*, cites three cases in which he has made careful observations as to the influence of the iodoform treatment upon the bacillus tuberculosis. In every case there were well-marked symptoms of phthisis—copious expectoration, rapid emaciation and pyrexia, while the physical signs of consolidation were unmistakable. The sputa contained numerous bacilli. Iodoform was administered, in doses of one grain every four hours, and gradually carried up to two, three and five grains, respectively. As a result of this treatment, the cough and expectoration ceased, there was a notable increase in body weight, and the physical signs were greatly improved. The bacilli, which had been noticed in such numbers at first gradually disappeared from the sputa, until only a few remained. The writer acknowledges that these were selected cases, but he feels justified, from the evidence obtained, in assuming that iodoform really exercises a germicidal action upon the micro-organisms of tuberculosis.—*N. Y. Med. Journal.*

Whooping-Couch and Resorcin.—A monograph on the nature and treatment of whooping-cough has recently appeared at Rio de Janeiro from the pen of Dr. Moncorvo. He accepts, in a great measure, the consequences of the germ theory as regards pertussis and looks on the affection as due to the presence of micrococci, which proliferate abundantly upon the mucous membrane which coats the upper part of the larynx above the rima glottidis, where the epithelial cells become infiltrated, and which region appears to be the seat of election for the proliferation of the micrococci. Resor-

cin directly applied to the mucous membrane of the region indicated has led to diminution in the number of spasmodic attacks, which lose their intensity, while the total duration of the disease is shortened. The benefit is said to be wholly due to the resorcin, because no other means were employed. The drug was used in the strength of a one per cent. aqueous solution as a topical application, by means of a soft brush mounted on a long handle. The application was made three, four or five times a day.—*London Lancet.*

The Occurrence of Ascaris Mystax in the Human Body.—Dr. Howard A. Kelly, of Philadelphia, reports, in the October Number of *The American Journal of the Medical Sciences*, a case of the occurrence of this rare worm in the human body. It is believed to be the ninth case on record, and the first observed in this country. Dr. Kelly believes that it is simply an accidental parasite in the human body, and that it is probably but one of the rarer of the risks from using food contaminated by filth.

Medical Items.

Dr. Geo. W. Pollard, of King and Queen Co., Va., died December 5th, of consumption.

The new Insane Asylum at Bayview Hospital, Baltimore, will be open for the reception of the pauper insane in a few days. It will accommodate from 300 to 400 persons.

Dr. Walter Wyman, Surgeon Marine Hospital Service, left Baltimore last Wednesday for Europe. He will spend four months in Berlin and Vienna studying the cholera microbe.

Dr. Wm. A. Jones, Coroner of the Western District of Baltimore, has been appointed to succeed Dr. Byrd in the Chair of Obstetrics, Baltimore Medical College.

Dr. Geo. S. Kinnemon died Dec. 12th, in Baltimore, aged 36. He took his degree at the University of Maryland, in 1874.

Dr. Andrew Hartman died at his residence, in Baltimore Dec. 15th, of softening of the brain, æt. 66. He was a native of Pennsylvania, but came to Baltimore in 1845. He obtained his degree at the Washington University of Baltimore.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from Dec. 9, 1884, to Dec. 15, 1884.

Hammond, Jno. F., Colonel and Surgeon, retired from active service, by operation of law, on Dec. 4, 1884, under provision of Act of Congress approved June 30, 1882.

McKee, J. C., Major and Surgeon, leave of absence still further extended one month.

Landesdale, Jno. V., Captain and Assistant Surgeon (Ft. Sully, D. T.), granted leave of absence for one month, to take effect about Dec. 20, 1884.

Comegys, E. T., Captain and Assistant Surgeon, granted leave of absence for one month.

Porter, Jos. Y., Captain and Assistant Surgeon, sick, leave of absence extended four months on Surgeon's certificate of disability.

Kane, John J., Captain and Assistant Surgeon, from Department East to Willet's Point, New York.

Brewster, J. M., Captain and Assistant Surgeon (Ft. Adams, R.I.), granted one month leave of absence on surgeon's certificate of disability.

Pilcher, J. S., First Lieutenant and Assistant Surgeon, ordered to Ft. Cuter, M. T., for duty. Order assigning him to duty at Ft. A. Lincoln, D. T., amended.

Gray, Chas. C., Major (retired), died at Geneva, N. Y., Nov. 22, 1884, instead of Nov. 26th, as heretofore announced.

Official List of Changes in the Medical Corps of the U. S. Navy during the week ending Dec. 13, 1884.

Craig, T. C., Passed Assistant Surgeon, detached from Alliance and placed on waiting orders, Dec. 6, 1884.

Curtis, L. W., Assistant Surgeon, to the Naval Hospital, Chelsen, Dec. 9, 1884.

Gaines, J. H., Passed Assistant Surgeon, present duty continued.

Green, E. H., Passed Assistant Surgeon, special duty at Museum of Hygiene, Washington, Dec. 11, 1884.

Murray, J. M., Passed Assistant Surgeon, detached from Naval Hospital, Chelsea, to the Flagship Hartford, Dec. 9, 1884.

Woolverton, T., Surgeon, to the Shenandoah, Dec. 6, 1884.

Original Articles.

CYSTITIS IN THE FEMALE. *

BY J. TABER JOHNSON, M.D., WASHINGTON, D. C.

Gynæcologist of Providence Hospital.

It is not my intention to discuss the entire subject of cystitis in the female, as the title of my paper would indicate, but to present some points in the history of the case of one of the greatest sufferers which it has been my lot to care for since I began to practice medicine, and to submit a few remarks upon the treatment of the chronic form of this painful disease.

I have no data to show the frequency of chronic cystitis. I am impressed with the belief, however, that in the terrible form in which I observed it in this case, it is comparatively rare. That many women suffer from irritability of the bladder during pregnancy and the puerperal period, and that a mild or subacute variety of cystitis may accompany and complicate inflammation and displacements of the uterus, I am painfully aware. Indeed, I am surprised that they are not more frequent when I remember the compression the bladder undergoes in pregnancy, and especially during labor.

The frequency, causes, diagnosis, pathology and prognosis do not enter into the scope of this short paper.

Upon the importance of the subject, the character and degree of the sufferings of the victims of chronic cystitis I submit the opinions of two competent judges, one American and one English.

Emmet, p. 740 of his book, says "that before the last stage of the disease has been reached, the poor woman has experienced, through a series of years, an amount of suffering, both of mind and body, unequaled, I believe, in any other infirmity to which humanity is subject. To alleviate this suffering, these women soon become addicted to the use of opium, and it is almost incredible to what degree of tolerance to this drug they may attain."

An English author, Edis, describes the effects of this disease in the following words: "The bladder at first empties itself completely, but with the frequent efforts to force out the mucus, inflammation and thickening of the neck of the bladder ensue, which interfere with the complete evacuation of the urine. A certain amount of stale urine is thus habitually retained, which increases the irritation. The walls of the bladder become thickened, ulceration of the mucous membrane occurs, infiltration of urine may take place, abscesses form, and pelvic cellulitis or peritonitis may result. The entrance of the ureters into the bladder is often obstructed, the urine can no longer flow freely, and obstruction of the ureters occurs, inflammation extends along them to the kidneys, and these in time become disorganized by the accumulation of urine, death resulting from uræmic poisoning."

In some cases women continue to live on in spite of their unequaled sufferings, as Emmet terms it; and do not die of inflammation of the kidneys or uræmic poisoning, as, according to Edis, but live on, a torment to their numerous medical advisers and to themselves, until after many years of disappointment and failure they finally recover, the last attendant receiving the credit of the cure.

Such a case I have to report to-night. The notes were taken by Dr. Hammond, the Resident Physician of Providence Hospital, at my request, and some of the statements are in the exact words of the patient as she gave them to Dr. H.

Mrs. S. S., aged 36 years, was first troubled with inflammation of the bladder in the fall of 1873. She was suddenly seized with great pain and an incessant desire to pass her water. Micturition was always accompanied by severe straining efforts, and to use her own expression, her screams and groans could be heard for three squares. Says she was compelled to move to the suburbs of the village on account of the complaints of the neighbors; was under the care of a physician for three years, who treated her for womb disease. During these three years she was never able to walk a square. She had to sit most of the time, night as well as day, upon a "sick-chair."

After three years of this terrible agony. she became an inmate of an hospital for six months. Her condition was slightly improved, and her means being exhausted, she returned home.

In three weeks her trouble came on again as bad as ever. She states that she had an

* Read before the Medical Society, District of Columbia, Nov. 19, 1884.

attack of hemiplegia, which lasted but a short time.

She remained at home until the year 1880, during which time she was attended by various physicians, with no improvement. She was compelled to sit most of the time on the "sick-chair." Her calls to pass water were so frequent, and the pain was so great, if not immediately relieved, that she could not be more than a few moments away from the chair. Exercise of any kind increased the frequency and the pain of these demands to empty the bladder. She passed but a few drops at a time, but the pain was much lessened by even this slight discharge of urine. Before the pain entirely ceased, however, which was caused by the pressure of this very small quantity of water in the bladder and that produced by the severe straining effort to void it, another desire would be aroused by a few more drops having accumulated, and that would have to be expelled with much pain, and thus she passed her time hour by hour, day and night, for months and years, without relief.

In September, 1880, she again became a hospital patient for five months. During this time she states that she had two surgical operations performed. One being the removal of a polypus from the urethra and the other an artificial vesico-vaginal fistula, for the purpose of allowing the urine to dribble off as rapidly as it accumulated in the bladder. The fistula, she stated, soon healed, and she derived no benefit from either operation. Three weeks from this time her urethra was dilated, under ether, for the purpose of removing a stone from the bladder, which was supposed to be the cause of all her trouble, but no stone was found and no relief obtained.

Her symptoms remaining unchanged, except for the worse, she was tempted to give up all treatment and to go home and die, but she still persisted and remained for several months longer in the hospital.

With all the care which was exercised, the odors from her person and from her bed were so disagreeable to the other inmates of the ward that she states, for their protection as well as for her own good, she was isolated in a room in a part of the building where she could be as remote as possible from the other patients. At the end of five months she went home no better of her disease than when she came. Her general health had been somewhat improved. Had slept better and taken more nourishment.

For the next two years she found no relief from her sufferings. To use her own expression, she wore a urinal during the day and slept on a bedpan at night. She was able to do some work, but was never free from pain, except when she was under the influence of an anodyne.

In August, 1882, she entered the Providence Hospital and came under my care. I heard her story of years of suffering and entered on the treatment of her case with much reluctance and doubt. I never saw a greater sufferer from cancer, spinal or other disease. She was badly broken down. None of her organs were performing their functions well. She could only sleep when under the influence of opium. The bladder would tolerate but a few drops of urine. She was, therefore, compelled to micturate over a hundred times daily. She had an India-rubber urinal strapped over the vulva all day, and though her bed was covered with rubber blankets, she slept upon a bedpan at night, being roused from her sleep about every ten minutes to strain out less than a teaspoonful of urine.

The labia and adjacent skin far down upon the thighs was much thickened, excoriated and very sensitive. It resembled Russia leather more than natural skin. This patient was put upon a milk diet and an attempt made to build her up on tonics and the best hygienic regulations possible to secure. The usual remedies for inflammation of the bladder were prescribed, one after another, including buchu, urva ursi, belladonna, stigmata madis, borax, benzoic acid, hyosicamus, bicarb. sodæ, potass., dilute nitric acid, dilute drinks of flax-seed tea, with sweet spirits of nitre; balsam copaiba, tinct. cantharadis, copious drinks of Bethesda water, Buffalo Lithia water, etc., etc. She was kept quiet in bed, and hot fomentations and poultices applied over the hypogastrium and about the vulva, but with no more good effect than from whistling against the wind to quiet a storm at sea.

She was a nuisance in the hospital. The urine was offensive, notwithstanding the most constant efforts to prevent it. The patient was neat in her habits and was greatly distressed at the constant smell of ammoniacal urine. Patients in the ward complained, and though she was removed to

the colored ward, two negro women left the hospital, as they were unwilling to sleep in the same room with my patient. She smelt bad; her clothing smelt bad, and her bed smelt worse, especially at night, when there were fewer doors and windows open than during the day, and consequently the ventilation less perfect. After three weeks of failure with remedies, I had her etherized, and with the assistance of Drs. Eliot and Sowers, thoroughly explored and examined her bladder with sounds and with the finger through the gradually dilated urethra. No fissures, ulcers or foreign body was detected, but the bladder was thickened, and its lining membrane was arranged in folds resembling the internal surface of the vagina.

After passing my little finger, I slowly pressed in the index finger. Drs. E. and S. both passed their index fingers. The urethra was thoroughly dilated; thus, while aiding in the diagnosis, the dilation became at the same time a useful mode of treatment.

Mrs. S. was greatly benefitted by this dilatation of her urethra; for a time temporary incontinence of urine was produced, and while it continued she was saved the painful straining efforts to expel the urine. It ran away as fast as it accumulated.

I was surprised that she was not relieved by the opening made into the bladder several years before. Perhaps she might have been if it had not healed too soon. I was never able to discover any evidence of such an operation, and have sometimes doubted if she fully understood what was done, though she was a very intelligent woman. She had been at one time matron of one institution and nurse in another.

She remained in the hospital but three weeks, and we were all glad to have her go.

In January, 1883, a year and a-half later, she came back again. The incontinence had ceased, and all her old symptoms had returned. She was constantly in pain, which was now greatly aggravated when she passed water. After about two months of ineffective treatment, I began to wash her bladder out twice daily with a quart of warm water impregnated with borax and glycerine, and immediately afterwards an injection was made of nitrate of silver, two grs. to the ounce of water. The strength of this injection was gradually increased to four grs. to the ounce. I ordered for her also an infusion of sorghum vulgarare, to be taken internally in large doses, say two tumblerfuls during the day as a drink. I am indebted to Dr. Garnett for the suggestion of this remedy, whose article upon its beneficial effects in affections of the bladder I had read in the *Am. Jour. of Med. Sciences.*

The patient immediately began to improve, and to make a long story short, she soon got on without the urinal by day and the bed-pan by night; and on the 23d of April, 1883, she left the hospital entirely well. The day before leaving she held her water four hours at a time, and slept at night from 10 P. M. to 6 A. M. without a single disturbance.

About one year from this date, the 19th of February, 1884, she called at my office and reported herself in good health; says she can hold her water as long as any one, and passes it without pain.

She is the most grateful patient I ever saw, but she ascribes her cure largely to the marvelous interposition of Divine Providence. After eleven years of such terrible suffering, to be cured in about six weeks she thought beyond the power of man, especially when she remembered all the treatment, all the doctors, and all the failures to cure.

It may be proper to add that the only uterine disease which I discovered was a mild form of chronic cervical catarrh. She occasionally had some vaginal leucorrhœa. Her periods were normal.

The treatment of chronic cystitis in the female is no easy matter. Few of the severe maladies we are called upon to treat are so irresponsive to remedies. In some cases our efforts fail, and the patients suffer on until they die of exhaustion, kidney inflammation or uræmia.

Thorough and frequent washing out of the bladder, cleansing it of stale, offensive ammoniacal urine, stringy mucus and phosphatic deposits, purifying its diseased and perhaps ulcerated surfaces ought certainly and frequently, will have beneficial and even curative effects. To follow this up with the injection of a mild solution of nitrate of silver has the endorsement of the best authorities. In my case no better result could have been obtained or desired. But, unfortunately, all cases will not respond so satisfactorily. What is left to be done when all such means as have been

mentioned, and all others which may be discovered in the future, fail?

I believe that to surgery we may confidently look for help, if not for cure, in a certain proportion of these distressing cases. Thus Emmet says, p. 742: "When the injection of water cannot be borne without increasing the irritation of the bladder, or where there had been no marked improvement in the case after a reasonable time, a surgical operation must be resorted to. This consists in making an opening in the vesico-vaginal septum, through which the urine may escape into the vagina as rapidly as it enters the bladder. In this way absolute rest of the organ is secured, and the inflammation will subside." This is very strong language, but from such a master as Emmet, will be accepted by many as law and gospel, and much harm may be done in the making of vesico-vaginal fistulæ when less radical treatment would have sufficed.

The operation is not devoid of danger, and should be caerfully considered as well as carefully performed. There is danger of cutting into the neck of the bladder; there is danger of cutting into good sized arterial branches and causing severe hemorrhage, and there is danger of injuring the ureters.

There is difficulty in keeping the edges of these artificial fistulæ from healing together before any good is accomplished, and a number of devices have been suggested to prevent this accident. Emmet uses a glass islet or perforated stud which he buttons into the opening. Pallen performed the operation with thermo-cautery; others operate with the knife and scissors, and then sere the edges with the cautery; and tubes have been inserted which accomplished this purpose, while at the same time they carried the urine safely over the parts into a vessel under the bed.

Dr. Willard Parker first operated for the cure of cystitis upon this plan, on the 23d of November, 1850, in Bellevue Hospital, upon a man suffering with chronic cystitis. He says, "The object in view was to open a canal by which the urine could drain off as fast as secreted, and thus afford rest to the bladder, the first essential indication in the treatment of inflammation." Drs. Sims, Emmet, and Bozeman operated subsequently upon the female bladder upon the same principle, with success.

Skene, in his book on the Diseases of the Bladder and Urethra in Women, suggests that while this operation is conceived upon a correct principle that rest to the inflamed bladder can be secured upon a simpler and less dangerous plan, viz.: by the dilatation of the urethra, thus producing a temporary incontinence of urine, or by the wearing of a Skene-Goodman catheter so retained in the bladder as to give little or no pain or annoyance to the patient.

To those who are accustomed to successfully operate upon the female bladder and vagina, and who have skillful assistants and trained nurses to care for their patients, and who are thoroughly competent to close the fistulæ subsequently, this operation will probably be the operation of the future in these cases which resist other modes of treatment, but to the very large class of less skilled physicians who have not all these modern improvements at their command, the dilatation of the urethra and the retention of the catheter will be most frequently resorted to.

I suggest these points of surgical practice for discussion and also the practice of injecting into the bladder various medicated fluids, both for cleansing and healing purposes.

MEDICAL ECONOMICS FROM THE STANDPOINT OF THE GENERAL PRACTITIONER.*

BY W. N. HILL, M. D., OF BALTIMORE.

The renewed agitation of the subject of legal restriction to practicing medicine is a sufficient apology for some effort to be made for finding out and studying the true relations of our profession to the general public. As yet, as far as the writer can see, the subject has only been treated in an amateur manner, and not in the true scientific spirit that should guide us as to cause and effect, which obtains in other matters embraced in the practice of medicine. During every period of business dulness in this country, a renewed discussion of the subject has taken place; always with remedies for the evils under which the profession labor, partaking of the nature of

* Read before the Medical and Surgical Society of Baltimore, Dec. 17, 1884.

temporary expedients. The object of this paper is to show the present state of the profession and the cause of great pecuniary distress under which many members of the profession labor, giving them the notion, more or less true, that owing to the overstocked condition of the market there is no demand for their services.

Our profession, in a business point of view, may be divided into four classes: (1) Medical Journalists; (2) Faculties of Colleges; (3) General Practitioners; (4) Specialists.

The journalist expects to derive his support from the practitioners of all shades; the college men have advantages over all others, given them by the law; the specialist being, as a rule, also a college man, may be considered as belonging to that class.

All the different divisions of labor in the medical world are, more or less, dependent upon the general practitioner, and, at the same time, tend to deprive him of the rewards of professional work and the opportunity to gain that skill so necessary for success.

The census of the United States, for the last forty years, shows that during the time specified the population of the country and of the State of Maryland has increased at greater ratio than the number of physicians resident therein, respectively. From this fact, it would appear that it is not an oversupply altogether that causes the prevailing distress and consequent dissatisfaction.

It is probable that a partial solution of the problem may be found in the fact (if fact it be) that the supply of physicians may be in excess in some parts, while in others it is below the average. I have compiled the following statistics bearing on this point from the most trustworthy sources. The figures given for 1850 and 1860 are taken from the "Medical Annals," and those for 1870 and 1880 from the directories of the city. The numbers for the State were obtained by subtracting the number in the city from the number returned in the United State census for the years mentioned.

It will be observed that the number of physicians in Baltimore has increased over four and a half times, whereas the population has increased a little over two times, and the number of persons to each physician has decreased almost one half. The proportion in the State has not varied in the same striking manner.

TABLE OF STATISTICS.

Year.	Population of Balto. City.	Number of Physicians in Balto.	Proportion of Physicians to Pop. of Balto. one to
1850	169 056	139	1,216
1860	212,418	325	653
1870	352,182	456	772
1880	393,796	679	579

Year.	Population of Maryland. outside Balto	Number of Physicians in Maryland. outside Balto	Proportion of Physicians to Pop. of Md. one to
1850	388,978	851	457
1860	474,631	768	616
1870	428,712	801	535
1880	541,147	872	620

Among all the professions, I believe the medical is unique in having failed to place a limit to its membership. The clergy of the various denominations have a more or less severe ordeal to pass through, and their fellows sit in judgment on them before they are allowed any privileges connected with their profession. The legal or other professions also place some limit under sanction of the law or by force of custom.

The idea of decreasing the members in our profession, either by legal means or otherwise, is distasteful to many of our professional members. They say it savors of trade-unionism; has a tendency to degrade the profession, etc.

It seems strange to me that such frequent reiterations of the cry that there are too many doctors should fail to find acceptance with those who guard the entrance to our profession. The manufacture of doctors goes on at a faster rate than it did formerly. In 1870, according to the reports of the Commissioner of Education, there were in the United States 72 medical schools with 5,956 students; in 1880, the number has increased to 90 schools with 11,801 students. What it is at the present time I have no means of determining, but am sure that there is no diminution in the numbers.

"All writers on political economy enforce the view that the degree to which wages are lowered by the presence of an

excess of labor in the market is wholly out of proportion to the amount by which each man would have his receipts lowered, if the labor which is in excess were to be paid out of the former gross sum of wages paid."

The competition to which we, as practitioners in the future, will be subjected, will still further reduce our incomes if things keep on at the present rate. It is no doubt difficult for many practitioners of high standing and lucrative practice to realize that the profession is overstocked. They do not feel it, being the fortunate occupants of exceptional positions. Yet, when we consider the long period of years necessary for them to obtain their present position, we cannot but see there is something wrong when they can only obtain the partial acme of their ambitions when the best of their years are gone. To those who say that limiting our numbers smacks of tradesunions, we answer, better let us have tradesunion than the present prospect of slow starvation. The practice of medicine is by no means an hygienic occupation. It brings the practitioner into all manner of unwholesome surroundings, and we add to all the worries of practice the gaunt figure of poverty constantly wearing out the poor practitioner with its terrors not only to himself, but also to the wife and little ones who are dependent upon him. Too frequently it happens when the bread-winner of a medical family is taken their all goes with him. The family accustomed to comforts, if not to luxury, is reduced to penury.

And now a few words as to how this decrease in our numbers may be attained. Without a more thorough organization our efforts will be ineffectual. Organization is the only method by which we can make ourselves felt. It necessitates discipline and obedience. The ability to carry it out successfully is one of the highest attributes of man. In fact, by some philosophers it is considered the distinctive point between sanity and lunacy. Each one of us should drop our petty personalities and work together for the common good, for there is much to be done. The public has always made a victim of the medical profession, and it will continue to do so unless we make an effort to defend ourselves.

The organization of the legal profession under sanction of special privileges given them by the law, is of great benefit to them. A good illustration of the benefits that accrue to the lawyers may be found in a comparison of the emoluments of offices held by lawyers and those held by medical men. We are called to court and compelled to testify without remuneration, to be badgered by lawyers; and we cannot legally refuse to go. Whereas, who ever heard of a lawyer rendering any kind of public service for nothing. But no action on this or any other matter relating to our profession can be taken until we have more effective organization. This matter of our future organization has been the subject of thought to the writer for a number of years, and he ventures with diffidence to make known the plan he has devised. There are at present in our city four Medical Societies, and my proposition is that they should form a partial union; the membership in each to consist of those practitioners resident in each of the three legislative districts of the city. A gentleman joining one division should have all the privileges of a member in the other Societies, except the right to vote. A uniform fee might be exacted, which would go into common fund to pay the necessary expenditures of each branch. Each Society would remain as at present organized, and in all matters pertaining to itself, would have full authority to do as it pleases. I make this suggestion in the hope that it will at all events provoke a more extended discussion of the subject than has recently taken place.

Society Reports.

PROCEEDINGS OF THE MEDICAL SOCIETY, DISTRICT OF COLUMBIA.

(*Specially Reported for Md. Med. Journ.*).

STATED MEETING HELD NOV. 19TH, 1884.

The Society met with DR. WM. G. PALMER in the Chair, DR. WM. H. TAYLOR, Secretary.

Under miscellaneous business, *Dr. John B. Hamilton* offered the following resolution, which was unanimously passed.

Resolved, That in the opinion of the Medical Society of the District of Colum-

bia, in view of the danger to our country, from the threatened introduction of cholera, the prohibition of the importation of old rags from foreign countries infected with cholera is a necessary measure in the interest of the public health.

The resolution was seconded by *Dr. Toner*, who spoke of the great importance of considering this subject at the present time.

Dr. Lovejoy was in favor of the resolution, but was of the opinion that the baggage of emigrants from infected districts and their personal effects, other than wearing apparel, should be included in the prohibition; or such measures taken as to insure their complete disinfection, as one single infected garment may convey the disease germ and start the spread of contagion as effectually as a cargo of old rags.

Dr. Mauss said he agreed with what Dr. Lovejoy had just said, but was of the opinion that such restrictive measures were hardly practicable.

Dr. Schaeffer spoke of the great danger of the disease being imported into the country by means of the household utensils, beds and bedding, old clothes and other effects of immigrants.

Dr. Hamilton said he would not take up the time of the Society in discussing old rags, but he considered the question of the introduction of cholera into this county a matter of very vast importance, and deserving consideration and attention, especially for members of the medical profession at this particular time, as it was declared by interested parties that the profession was not in accord with those advocating the enforcement of such strict precautionary regulations, and he thought it would have a very good effect for this Society to express a decided opinion on the subject.

Under the call for pathological specimens, *Dr. Reyburn* presented

A FATTY TUMOR

removed by him to-day, from the right groin of a man, a patient in Providence Hospital. He said he presented the specimen to show that what was very evidently an ordinary fatty tumor had, apparently, taken on malignant action from simple mechanical irritation incident to its position.

The specimen was, on motion, referred to the Microscopical Committee.

Dr. Lamb presented a brain and gave the following description of the case:

"I here present a brain, with portions of the membranes removed, to show convolutions; many thin patches of blood-clot under membranes, more especially: first, over right temporo-parietal portion, corresponding with the greater external wound; second, over summit of right ascending frontal convolution, corresponding with small hemorrhagic clot in the substance just beneath; and third, over left ascending frontal and parietal convolutions, corresponding with a large hemorrhage in, and distinctive of large part of left supra-ventricular substance. In the recent state, the dura mater was somewhat congested; the pia mater was not noticeably so; subarachnoidal fluid increased in quantity and a small quantity of exudation.

The operation was upon a white man, aged 44, who fell from a street car, November 4th. Dr. G. W. Cook attended.

There was a laceration of scalp over right parietal eminence and a contusion over frontal eminence; also livid marks on the arm and leg. He soon recovered consciousnes and spoke as coherently as possible for a man who had been drinking freely for some days; paralysis of right arm and and leg; next morning he was in a stupor, but could be aroused by speaking to him; tried once, but could not talk nor protrude his tongue; passed urine and fæces involuntarily. Drs. N. S. Lincoln and D. Blair were called in consultation. On the night of the 6th inst. he had severe convulsions; next day there was priapism which persisted through four or five hours; some urine was removed by catheter and found to contain some albumen; pulse and temperature continued to rise from the beginning; died comatose on the 9th, five days after injury; treatment consisted of a mercurial purge, bromide of sodium and tincture of hops, and a little whisky and milk.

Autopsy, performed by myself, was limited to head; the lacerations penetrated to the bone; there was a zigzag fissure running backwards and to the right from the left side of frontal bone, about half an inch above orbit, ending near groove for middle meningeal artery; a second fissure beginning below right parietal eminence and ending forwards at the same groove; both tables involved, but no displacement; a small zigzag fissure in roof of tympanum and extravation of blood in apex of petrous portion.

Dr. J. T. Johnson read a paper on CYSTITIS IN THE FEMALE.

See this Number of the JOURNAL, p. 151.

DISCUSSION.

Dr. King said he would like to ask Dr. Johnson which remedy used in his case he considers effected the cure, sol. vulgarare or the injections? He had treated a case of cystitis with injections of solution of nitrate of silver, with great benefit to the bladder symptoms. The case was a complicated one; there was pelvic cellulitis which he thought gave rise to an abscess which opened first into the bladder, then externally through the abdominal wall. There was pus in the urine in such quantity as to indicate a fistulous opening between the bladder and the abscess. He had another case in which he effected a cure by washing out the bladder with solutions of carbolic acid and nitrate of silver. The great pain and suffering endured by Dr. Johnson's patient was no doubt due to the diseased condition of the urethra, as it was not usual for disease in the bladder to cause pain of the character described. In answer to a question by Dr. Hamilton as to how he accounted for there not being great extravasion of urine in his case of pelvic abscess, Dr. King said he presumed there were adhesions between the wall of the abscess and the walls of the bladder.

Dr. Mauss said he came to hear Dr. Johnson's case, as he had a case on his hands now that was very much like it, and had given him no little trouble and taken up much of his time. He had gone through with the whole list of remedies narrated by Dr. Johnson, and all to little purpose. He had used injections of water in the bladder, but not with the intention so much of washing out the bladder as of distending the bladder and thus making it more tolerant of distention by urine, but it did not effect that purpose. He tried to distend the bladder with a tupelo tent introduced half an inch into the urethra, but the tent became swollen in the shape of a burr and was difficult to remove. The best mode of dilating the urethra was with the catheter. He had used solution of nitrate of silver, one grain to the ounce of water, but with no benefit. Opium and cubebs had been of more service than anything else tried.

Dr. Fry said he had not had any cases as bad as those narrated, but that he had derived great benefit in his cases by washing out the bladder well with warm water; he used a double catheter for this purpose, which effectually washed out the bladder. Cystitis was frequently accompanied by an irritable condition of the urethra. In these cases he made applications to the urethra and fully dilated with male steel sounds.

Dr Schaeffer spoke of the case of a man who suffered for years with cystitis, and he said from what he saw in this case, he would have more confidence in the plan of treatment advocated by Beale, of England, who recommended constitutional in connection with local treatment. He believed in building up the system by nourishing diet and the judicious use of stimulants.

Dr. Thompson said these cases of cystic disease were of great interest. The case narrated by Dr. J. T. Johnson, he thought, demonstrated quite clearly the inutility of drugs in these diseased conditions of the bladder. He was surprised that the treatment last resorted to in the case was not the first adopted. Surgical treatment had been so unsatisfactory in these cases of long standing that it was not now generally upheld by the profession. Dilatation or section was generally followed by temporary relief, but further than that it did not accomplish much. It was impossible to do much good in old cases. The last mode of treatment, brought up of late years, was injections of strong solutions of nitrate of silver; twenty and even thirty grains to the ounce are used. The profession generally have too much fear of these injections. It is not the rule, though, to use solutions of this strength in all cases. He saw Von Dettel open the bladder through the perineum in the case of a boy, and in five days a cast of the bladder was discharged and the case was perfectly cured. He (Dr. Thompson) believed in the strong injections.

Dr. Lovejoy said he remembered several cases of inflammation of the bladder that had occurred in his practice. One case was that of a young woman who had suffered extremely for some years. The number of times that she said she had to get up at night to urinate was incredible. He told her to keep count by taking a piece of paper to bed with her and snipping off a piece with scissors every time she got up to urinate. She did so, and the count was

forty times in one night. He adopted a plan of treatment recommended by Sir Henry Thompson, in an article published in the *London Lancet*, which was to inject the bladder twice daily with a solution of two ounces of glycerine and two of water, and one ounce of borax. After this injection, the eighth of a grain of sulphate of morphia dissolved in two drachms of water was thrown in the bladder. This solution of morphia quieted the bladder, and contrary to the experience of Sir H. Thompson, produced the full effect of a dose of a fourth of a grain given hypodermically. This treatment had a most satisfactory effect, reducing the number of times she had to get up to pass water from forty to four times a night. The treatment was continued for a long time, but the patient finally was worn out with the disease and died. Had the case come under treatment sooner the result would have in all probability been different. Another case related, where there was great irritability of the urethra with cystitis following labor, was cured by bougies coated with mucilage and tannic acid, dried, and dipped in gum water when used. After a few times the symptoms were greatly improved, and in from seven to ten days the case was cured.

Dr. Magruder said he had not attended many cases of the disease under discussion and he did not wish at this late hour to give an extended account of the cases he had seen, but he would like to state one or two points in regard to one or two of them. One case of cystitis he had treated, as he thought, with great advantage by large doses of quinine, ten grains two or three times a day. He had also used quinine injections with beneficial results. He called to mind the case of a gentleman suffering from gleet, who, upon his own notion and responsibility, used an injection of quinine, with the effect of curing the gleet. He had sometimes dilated the urethra with sponge tents. In one case he had done so and removed a stone in the bladder which had heen the cause of the cystitis. In regard to the statement of Dr. Lovejoy, that an injection of morphia into the bladder in the case related by him, having produced in the girl the full anodyne effect of the drug, he would say that many of the writers on materia medica now mentioned the absorbant powers of the bladder, and drawing attention to that fact, recommended, in cases of poisoning, that the bladder should be evacuated to obviate the danger of reabsorption of the poison that might be retained in that receptacle; and on the other hand, had suggested the administration of medicines by the bladder when, through irritability of the stomach, they could not be given in the ordinary way, or by hypodermic injection.

On motion, the Society then adjourned.

CLINICAL SOCIETY OF MARYLAND

STATED MEETING HELD DEC. 5TH, 1884.

(*Specially Reported for the Md. Med. Journal.*)

The Society met at the usual hour, the President, Dr. B. B. Browne, in the Chair.

Dr. G. M. Sternberg read the first paper of the evening, his subject being,

"WHAT IS THE EXPLANATION OF ACQUIRED IMMUNITY FROM INFECTIOUS DISEASES."

Three explanations have been offered, viz.:

(*a*) The "exhaustion theory" proposed by Pasteur (*Comptes rendus Acad. des Sc.*, xc., pp. 952, 958), which supposes that some substance present in the body of a susceptible individual up to the time of a first attack, and which is essential for the development of the specific germ of the disease, is exhausted during the attack, and that consequently this particular germ is unable subsequently to multiply in the body of this individual.

(*b*) The "antidote theory," which supposes that some chemical substance is produced during the attack which is inimical to the development of the germ, and which, remaining in the body of the individual, prevents its subsequent invasion by the same microbe. (This theory has been advocated by Paul Best, by Klebs, and recently by Klein, in his *Micro-Organisms and Disease. The Practitioner*, London, Vol. 33, No. IV., p. 249).

(*c*) The "vital resistance theory," which supposes that immunity is due to an acquired tolerance on the part of the living cellular elements of the body to the poisonous products produced by disease germs, to which they probably owe their specific

pathogenic power, and a consequent ability to resist invasion by these germs. According to this view individual and race differences in susceptibility, as well as the more or less perfect immunity resulting from a single attack of any one of the specific infectious diseases, are phenomena depending upon differences in vital resisting power, either inherited or acquired. (This view was supported by the present writer in a paper published in the *Am. Journal of the Medical Sciences*, of April 1st, 1881, and by Grawitz, in a paper published in Virchow's *Archiv.*, on the 8th of April, 1881. It has also been ably advocated by Salmon).

The first explanation (*a*) is untenable for the following reasons:

Our credulity is overtaxed by the supposition that various chemical substances essential for the development of each of the specific disease germs are stored up in the blood and tissues from birth until the date of attack, in spite of nature's provision for the excretion of useless or injurious products; that these several substances are exhausted only by the development of particular disease germs, *e. g.*, one substance by the germ of small-pox, one by that of measles, etc., etc.; that these substances are formed and stored up in the body for no other apparent purpose than to serve as pabulum for various disease germs; and that, having served this purpose once, they are not reformed as a result of the continuence, after recovery from an attack, of the same physiological processes to which their origin must have been due in the first instance.

The protection resulting from inoculations with "attenuated virus" is also opposed to this view. For it is impossible to believe, for example, that the pabulum which would have nourished the small-pox germ in sufficient numbers to produce a malignant case of small-pox, is exhausted by vaccination.

Finally, we have experimental evidence that the theory is not correct. Salmon has shown that the flesh of a fowl which has an immunity from fowl cholera as a result of inoculations with attenuated virus, when made into *bouillon*, furnishes a good culture-medium for the microbe of this disease. And Klein states that "when of the tissues of a guinea-pig, or mouse, or rabbit, dead of anthrax, an infusion is made, and this is used as nourishing material for bacillus anthracis in artificial cultures, it is found that these latter thrive spendidly." (*The Practitioner*, Lond., Oct., 1884, p. 248).

The "antidote theory" is equally untenable and for similar reasons. It is difficult to believe that when we vaccinate an infant a chemical substance is formed and stored up in the tissues in spite of the changes due to physiological processes constantly going on in the body, in sufficient quantity to prevent the development of the small-pox germ for years, and perhaps during the life-time of the individual. Moreover, this theory requires us to admit that each specific disease germ has a special antidote which is produced only by its own vital processes, and that one or several of these peculiar chemical substances, stored up in the body of an individual, does not prevent the development of other disease germs; whereas, all of those chemical substances which have been proved by laboratory experiments to prevent the development of germs, *e. g.*, mercuric bichloride, are antidotes for all known organisms of the class to which disease germs belong, although not always in the same amounts.

Finally, the experimental evidence referred to as opposed to the exhaustion theory, is equally fatal to the antidote theory; for, if the micrococcus of fowl cholera, or the anthrax bacillus are prevented from multiplying in the blood and tissues of an immune animal by the presence of a chemical substance inimical to their development, then this substance should also prevent the development of these microbes in blood drawn from the vessels of such an immune animal, or in *bouillon* made from its flesh; whereas, the experiments of Salmon and of Klein, above referred to, show that this is not the case. We must therefore reject this theory as untenable.

The "vital resistance theory," as above formulated, is supported by numerous facts and arguments which may be briefly stated as follows:

There is a great difference in individual susceptibility to first attacks, and in the degree of immunity conferred by a single attack. Some individuals resist repeated exposure under the most trying circumstances, while others suffer an attack from the slightest possible exposure.

Individual susceptibility also varies greatly at different times, and is increased by depressing influences, such as fatigue,

fear, inanition, inebriation, hemorrhage, chronic wasting diseases, etc.

Unusual resisting power may, in some cases at least, be overcome by exceptionally large doses of the infectious material, and this is true as well of acquired immunity as of inherited insusceptibility. Second attacks of the infectious diseases may occur and are sometimes fatal. In other words, immunity is not absolute but relative. We have also examples of relative race immunity, as, for example, in the comparative insusceptibility of the negro to yellow fever, as to the effects of the malarial poison, and in the immunity of Algerian sheep from anthrax. This race immunity is doubtless due to a tolerance established by natural selection in races exposed for many generations to the continuous action of these poisons.

On the other hand, infectious diseases are exceptionally malignant when first introduced in a virgin population.

Physicians are familiar with numerous examples of acquired tolerance to toxic agents, *e. g.*, to opium, tobacco, arsenic, etc.

We know that living tissues and blood within the veins of a living animal resist the invasion of putrefactive organisms; whereas, a severed limb, or blood drawn from the veins into a test tube, quickly undergoes putrefaction. This may serve as an example of vital resistance to invasion by micro-organisms of the same class to which disease germs belong.

The tolerance, or increased vital resistance, which, according to this hypothesis, is acquired by the living cellular elements of the body, during an attack of one of the infectious diseases, to the toxic agent which gives the germ its specific pathogenic power, must be transmitted through successive generations of cells—nerve cells, gland cells, epithelium cells, leucocytes, etc.—in order to explain continued immunity, inasmuch as the cellular elements of the body are constantly undergoing destruction and are as constantly replaced by their cellular progeny. Biologists will have no difficulty in believing that this is the case, and that under the influence of the laws which govern the hereditary transmission of acquired properties from cell to cell, the tolerance acquired during an attack has a more or less permanent character Numerous examples might be given in support of this view.

Acquired characters are not, however, as a rule, transmitted through the sperm cell, or germ cell, to the off-spring of the individual. Our explanation is therefore not opposed by the fact that the children of immune individuals do not inherit immunity. As already stated, race immunity results rather from the continued action of the laws of natural selection, and the survival of the least susceptible from birth, an inherited insusceptibility which is transmitted to the off-spring.

Dr. I. E. Atkinson remarked that to him the paper of Dr. Sternberg had been most interesting and convincing. The objection urged against the first two theories of protection seemed conclusive and with the theory advanced by Dr. Sternberg he entirely concurred. There seems to be every reason to conclude that the virus of a specific fever exerts its action upon the tissue cells of the organism, not upon the fluids. This is shown grossly in the behavior of the different specific fevers as affecting more strenuously some parts than others. In typhoid fever, Peyer's patches bear the stress of the noxious influence; in scarlatina, the skin and fauces; in measles, the skin and bronchial mucous membrane, etc. Even in the same individual different parts of the same tract are differently affected, as in the circumscribed patches of the measles eruption, the scattered pustules of small-pox. Then the behaviour of a specific fever in affecting different individuals is most unequal. These considerations lead to the conclusion inevitably, that there must be different degrees of susceptibility of different tissues of the one individual, or in other words that certain cellular elements resist more successfully the morbific influence than others. When the resistance is least, the greatest number of elements is overcome and the patient succumbs; when it is greatest, the morbid action is trivial. A person, who recovers from a specific fever does so with such of his living tissues, such of the protoplasm of his body, as has successfully resisted the morbid influence of the specific principle. Throughout his subsequent life all his tissues are descended from those elements that have successfully emerged from the battle and inherit the properties of their progenitors. All tissues unable to resist the influence have gone under and are not represented, subsequently in the life processes of the person. We

have here a striking instance of the survival of the fittest. The entire organism is now competent to successfully resist the attacks of the specific agent and the individual remains protected almost always throughout life. That the offspring is in like manner protected, may be accounted for by the tendency to reversion toward ancestral modes of life, so often observed in the offspring, a tendency in which abnormal and intercurrent vital influences yield before the pressure of normal and persistent vital influences. But that the long-continued and repeated action of these intercurrent influences may effect permanent alteration in vital activities is shown in the much less virulent action of specific diseases in nations where they have been long prevalent, than in people among whom they are introduced for the first time. Dr. Atkinson read from an article of his published in the Transactions of the Medical and Chirurgical Faculty of Maryland, in 1875, nearly ten years ago, in which these views were advanced, views that he thought were essentially identical with those advanced in the paper of Dr. Sternberg.

Dr. P. C. Williams thought we had not yet reached anything like a positive conclusion in the matter, and that Dr. Atkinson's theory was simply another way of stating the exhaustion theory of Pasteur. We are at a loss to explain the immunity. The protoplasm, if once exhausted, ought to propagate itself, and thus the children of protected parents should be themselves protected, but such we know not to be the case. If the vital resistance should be sufficient to protect against a second attack why not against a first.

Dr. Councilman thought that one of Dr. Williams' objections would not always hold good, for in small-pox a slight immunity in the descendants of those who have had the disease does exist. In new communities the diseases were more fatal than in those which had been subject to the diseases for a long time and the following well illustrates this: Eight Esquimaux were brought to Germany; four were vaccinated with virus in Berlin, two died and two were very ill; four were vaccinated in Paris, three of whom died.

Dr. Sternberg said he agreed with Dr. Atkinson, and thought their views similar.

Dr. C. W. Mitchell read the second paper of the evening upon

FUNCTIONAL MURMURS OF THE HEART.

(See the JOURNAL of Dec. 20th, p. 131.)

Dr. F. Donaldson thought the idea that part of the first sound of the heart was made by its contraction not true, for the experiment has been tried of tying back the valves when the sound entirely disappeared; he thought it may add some to its intensity. He agreed with Dr. Mitchell that not only the evidence given by the heart, but the condition of the whole body should be taken into account in deciding upon the nature of heart murmurs. He quoted from authors as showing that simple diminution of the red globules could not of itself cause a diminution of the sound. Hæmic murmurs are heard from one and a half to two inches left of sternum. Murmurs are produced, not at the orifice of pulmonary valves, but at the appendix to left auricle; these are in fact not inorganic, but organic, by insufficiency of mitral valves by which blood flows back into appendix. Sufficient attention has not been called to the dilatation of the cavities as a cause of the heart murmurs.

Dr. H. C. McSherry said that the theory which Dr. Donaldson had referred to, the regurgitation into appendix, was advocated by Balfour, though Bramwell and Russell favor the purely pulmonic; the latter thinks the murmur due to constriction of the pulmonary artery by the dilated auricle. It is probable that in different cases the explanation of the murmur might be found in either of these theories. The Doctor thought valvular diseases might exist without any murmur as stated by Balfour, who said that some cases of mitral regurgitation could only be diagnosticated by a marked accentuation of pulmonic second sound. He thought the precordial murmur mentioned by Laennec had not received the attention it deserved; it was heard near apex of heart, and only when lungs were inflated, and was due to the compression of the lung tissue between heart and chest walls. He thought four elements went to make up the first sound, closure of auriculoventricular valves, contraction of the muscular tissue of the heart, impulse of heart against chest walls, and the rush of blood over the endocardium into aorta and pulmonary artery.

Dr. T. B. Brune had seen Dr. McSherry's point mentioned by Dr. Shattuck.

Dr. J. N. Mackenzie said that Flint also insisted upon it.

Dr. Branham thought regurgitations, such as were mentioned, were heard at apex of heart and not left of sternum. He thought first sound might be caused by choreic movements of the heart.

Dr. C. W. Mitchell said he knew of the diversity of opinion in regard to the cause of the first sound. Ludwig had produced the first sound after full removal of the valves. He thought the blood could not have its specific gravity so altered as to make it an element in the first sound. He did not believe in purely inorganic murmurs.

Dr. Chambers did not think choreic movements of the heart could be an element in its sounds. He thought the murmurs should be called remediable, not inorganic.

Dr. F. Donaldson, Jr., had often seen choreic movements in the hearts of dogs.

Dr. Chambers did not think we could take as a guide the action of an animal's heart outside of the body.

Dr. F. Donaldson, Jr., said the choreic movements had been produced by simply bleeding the animal.

Editorial.

Combined Turning in the Treatment of Placenta Previa.—It has been about a quarter of a century since Braxton Hicks first introduced the method of bimanual version and recommended it particularly for cases of placenta previa. Whilst this method of version has been accepted by the profession as one of the greatest improvements made in operative obstetrics, its adoption for the treatment of placenta previa does not seem to have been universal. Until quite recently we have seen no statistics to show that the prognosis of placenta previa is better when treated by this method than when treated by other methods. In the *American Journal of Obstetrics*, for December, Dr. Richard Lomer, assistant to the University Hospital for Women, in Berlin, presents statistics, and discusses the advantages of this method of treating placenta previa in an exhaustive and practical manner. Dr. Lomer gives the combined results of cases of placenta previa treated by bimanual version by Hofmeier and himself, at the University Hospital for Women, in Berlin, and by Behm, at the Charité Hospital, in Berlin.

Hofmeier is credited with thirty-seven cases, with one death; Behm with forty cases, no deaths; and Lomer with one hundred and one cases, with seven deaths, making a total of one hundred and seventy-eight cases of placenta previa, with a mortality of eight or 4.5 per cent.

These statistics compared with results of large collections of cases of placenta previa reported by different authors, show a most favorable prognosis for mothers. The prognosis of placenta previa for mothers has been regarded as extremely unfavorable, the percentage of deaths running from 8.5 per cent. to 35 per cent. More recent statistics show better results for all obstetric operations than those collected some years back, when antiseptics were less employed than at present, hence, in comparing statistics of now-a-days with those of years ago, this fact must be taken into account. That statistics may appear in their true light, Dr. Lomer gives a table in which other methods of treating placenta pervia were employed. Thus, of two hundred and thirty-six cases in hospital practice, where so many circumstances concur to deteriorate the prognosis, the mortality was ten per cent., whereas, those treated by the combined version gave the results above stated, 4.5 per cent.

Dr. Lomer next compares the mortality of children in placenta previa, as given by the different authors, with that in the series of cases above mentioned. According to the most favorable view of the mortality in placenta previa, the child has about three chances out of ten for being born alive. In comparing numbers with those of different authors, the conclusion is reached by Dr. Lomer that, 1. "The average mortality of children born spontaneously after turning is not superior to that of children extracted immediately after turning. The danger the child runs by not extracting it has therefore been overrated. 2. A child's life is of so little practical value in placenta previa, compared with the life of the mother, that, should it be endangered by leaving it to be born by natural powers, we are entitled to sacrifice it in cases in which we would endanger the mother by quick extraction."

In the employment of this method no regard is taken of the child's life.

If it is born alive all is well, if dead, the operator may console himself with the reflection that its life is of so little practical value in comparison with that of the mother that considerations for its welfare should not allow the mother to run the risk of fatal hemorrhage. The prognosis for the child being in all events bad in placenta previa, and not worse by this method than other methods, Dr. Lomer would not have the mother's life endangered to save the problematic life of the child. The results of this method of version being so surprisingly good for mothers, the claim for the superiority of the manner of proceeding is argued very forcibly.

The method advocated consists in turning the child by the bimanual method of Braxton Hicks as soon as possible. The leg and breech of the child are pulled down and used as a tampon for the ruptured vessels of the placenta. This done, the child is left to come by itself, or at least by the assistance of expulsion by gentle and rare tractions. The ordinary tampon is discarded, as much as possible, as a dangerous thing. Turning should be employed as soon as one or two fingers can pass through the cervix. If the placenta is in the way rupture the membranes at its margin; if this is not feasible, perforate the placenta with the finger, seize the leg as soon as possible and pull it down. "Up to this moment the treatment is an energetic, *active* one. Experience shows that flooding now ceases. The next part of the treatment is of an expectant nature. A quick extraction now would cause rupture of the cervix and fatal post-partum hemorrhage. Wait, therefore; give the patient time to rally her powers; wait until pains set in, and then assist Nature by exerting slow and gentle tractions. If the child is in danger during this time, let it run its risk, let it die if necessary, but do not endanger the mother by quick extraction."

Two sources of danger require to be taken into consideration in relation to the operation of turning in placenta previa: *First*, the danger of hemorrhage if the operation is not early performed; and *second*, the danger of laceration of the cervix and subsequent hemorrhage from its included vessels if delivery is accomplished too soon. The method recommended by Dr. Lomer seems to obviate both of these dangers. In turning early it arrests hemorrhage; in allowing nature to expel the child it prevents laceration of the cervix. It is very true this method considers only the welfare of the mother, and fails to take any account of the life of the child. If infant mortality is not made heavier—the statistics offered by Dr. Lomer favor this view—and maternal mortality is considerably reduced, those whose views may radically differ with Dr. Lomer as to the value of infant life, may nevertheless see in this method a valuable and practical treatment for a number of cases of placenta previa. This method of bimanual version cannot be substituted for the method of rupturing the membranes in head presentations in all cases. In fact, as Dr. Lomer argues, "circumstances must decide, in each special case, which treatment is most likely to be the best; no general line of conduct can here be given where so much depends upon the individual case." We think Dr. Lomer is very nearly right when he says, "very often it is the operator who settles the prognosis in placenta previa, and not the fact that he adopted this or that method;" nevertheless he shows that this method is entitled to more careful consideration than it has received.

The Revival of Ovariotomy in England.—In an address recently delivered (Nov. 5th) before the Midland Medical Society on the "The Revival of Ovariotomy and its Influence on Modern Surgery," Sir Spencer Wells makes the claim of having revived ovariotomy between the years 1858 and 1865. It was not supposed that this claim would be disputed, since the important work which Sir Spencer Wells has done in connection with this operation has so linked his name with ovariotomy that he has been almost universally regarded as the father of the modern operation. Perhaps no man now living has done more to develop and popularize this operation than Sir Spencer Wells. The fact that he has operated a larger number of times than any surgeon living or dead is in itself strong evidence of the justice of his claim. Mr. Lawson Tait, with his usual bold and decisive manner of challenging assertions, now makes the statement (*Med. Times and Gazette*, Nov. 29th, p. 763) that Sir Spencer Wells' claim cannot in the least degree be substantiated when the facts of the case are fully examined. Mr. Tait says "so far as has been discovered, the the first

ovarian tumor removed in England was by the hands of Dr. Charles Clay, on September 27th, 1842, all others, with the exception of one by Houston and another by Lizars, in Scotland, were clearly par-ovarian cysts. In 1843 Mr. Aston Key removed both ovaries, and Mr. Bransby Cooper also tried the operation in that year, but it was not till 1844 that there was a successful case in London operated on by Dr. Frederick Bird, followed by one in the practice of Mr. Lane. In the provinces, however, many successful cases had been done. In June, 1848, Dr. Charles Clay published a series of 32 cases, with 10 deaths, and in 1857 he had completed 77 cases, with 24 deaths. He operated continuously for many years till he had 395 cases, with 101 deaths, his total mortality being fractionally about 25 per cent., a mortality which I may remind Sir Spencer Wells is almost identical with that (25 per cent.) of his own 1,000 cases. At the same time the operation was being performed frequently in the large provincial towns of of England, but particularly in Manchester, by Southam and others with great success. The only revival, therefore, of ovariotomy which Sir Spencer Wells can lay any claims to is after its temporary decadence for two and a half years in London in the hands of Mr. Baker Brown, and even upon this point the evidence is by no means satisfactory. But if it is to be contended that from the time of McDowell till 1857 there was nothing being done in Ovariotomy, and that the revival there took place in that year at the hands of Mr. Spencer Wells, I say it may as well be claimed for him that he revived the moon."

Mr. Tait gives the credit of having established ovariotomy in England and of having carried it through its early struggles to Dr. Charles Clay, of Manchester, now living, but recently stricken down with paralysis, at the age of eighty-three. Dr. Clay's practice was, he says, a mistaken one in the use of the long ligatures, but its results were certainly no worse than those obtained by the clamp. Clay did not know of the results obtained by Nathan Smith by the use of the short ligature. "Had he done," says Mr. Tait, "abdominal surgery would have been half a century in advance of its present position, for then it would have been impossible for the clamp ever to have made its appearance. Baker Brown reintroduced Nathan Smith's principle and Keith brought it to perfection."

That portion of Sir Spencer Wells' address, in which he makes the claim now disputed by Mr. Tait, reads as follows: "In the *Brit. Med. Journal*, in 1873, Keith wrote: 'Few watched more eagerly than I did the history of this operation, and few knew so well the details of the early cases. Till 1858 I could find nothing whatever anywhere to encourage, but everything to deter one from attempting it. Ovariotomy was then, as an operation, simply nowhere, and had the practice of using Dr. Clay's long intra-peritoneal ligatures been continued, it would have yet been nowhere. Up till that year Mr. Brown had lost seven out of his nine patients, and had ceased operating for upwards of two years and a half. Surely there was nothing to learn from such results, except, perhaps, what there might be to avoid." Sir Spencer Wells then says, "Keith was one of the first to follow me, and did more than anyone else at that time to assist in the revival of ovariotomy. I had done eight cases when he began, and ever since we have gone on side by side, very friendly rivals, assisting each other, comparing notes, not always running on the same track, but always equally anxious to perfect the operation." "He concludes the letter, part of which I have just read, by asserting as others, both before and since, at home and abroad, have also done, and which it is my highest pride and pleasure to feel was not due only to their friendly feelings, but because it is true that the period of progress, the revival of ovariotomy, began when the results of my early operations were made known, and the confidence of the profession was obtained by the publication of every case, whether successful or not."

Anæsthetics and Their Administration.—Much has been written on the above named subject and much more remains to be written until the profession has clear, well-defined and practical views of its importance. Quite recently attention has been again called to the use and relative merits of various anæsthetics and their administration by Mr. Woodhouse Braine, of England. In a paper read before the Medical Society of London, Nov. 24th, 1884, and published in abstract in the *Lond. Med. Times* (Nov. 29th), Mr. Braine presents

facts quite worthy of notice here. Anæsthetics were divided into two classes—(1) Those which produced death through the lungs as well as through the heart; this class included chloroform, bichloride of methelene, bichloride of ethidene, and many others of the chlorine series; (2) Those which produced death through the lungs alone, the heart's action continuing for some time after respiration had ceased; this class included ether and nitrous oxide. In choosing anæsthetics there were three factors to be considered—(1) The nature of the operation; (2) The amount of insensibility necessary; (3) The length of time during which insensibility had to be kept up. This was illustrated by the operation of ovariotomy, which, after the first incision, occasioned little, if any, pain, and required the smallest degree of anæsthesia.

Of all anæsthetic agents, the quickest and safest, but the most difficult to administer really well, was nitrous oxide; to get its full effect it should be administered pure, all air being excluded; deep snoring and an insensitive conjunctiva were the best signs of insensibility. In regard to ether, the chief reason against its making its way was the difficulty of its administration. His usual practice was to induce complete insensibility by means of nitrous oxide, and then quickly change the face piece for the inhaler. This ought to be done very rapidly, so that the nitrous oxide which the patient gets rid of by the first subsequent expiration, passes through the sponge and becomes charged with ether for the first inspiration. After complete anæsthesia has been produced in this manner, the sponge may be removed, and the insensibility may be prolonged by allowing the patient to breathe from the India-rubber bag, admitting fresh air only as required. This primary anæsthesia may, in our opinion, be induced more easily and pleasantly by the use of chloroform or of bromide of ethyl, the ether being substituted, if found desirable, later in the operation. Ether, it is true, has a great advantage over those anæsthetics which depress the heart's action, and the same may be said for the nitrous oxide. The tendency of chloroform is to produce syncope, but whenever this appears imminent a few whiffs of nitrite of amyl is the quickest means of restoring the heart's action.

Dr. Braine insists that the anæsthetist, besides having nitrite of amyl, ought always to be provided with a pair of tongue forceps and the instruments necessary for tracheotomy, precautionary measures which we consider well-advised.

The nausea and sickness following the administration of anæsthetics require frequently much attention. We have witnessed more than one patient seriously depressed by this symptom, and the treatment of the case greatly complicated by the distress thus induced. Sickness after ether, Mr. Braine thinks due to large quantities of flatus; it generally takes place suddenly and forcibly, that after chloroform coming on more quietly. Hiccough is best relieved by a cup of tea without either milk or sugar. The stomach should be empty prior to the operation, still he would not allow a patient to become faint for want of food. "If the operation was arranged for 9 A. M., no food should be eaten, unless the patient was *in the habit* of having a small cup of cocoa or something, then this might be allowed, for its privation might cause the patient to feel faint. It was a bad practice to give the breakfast before the usual time, for the stomach, not accustomed to it, failed to digest the unusually early meal." An examination of the organs of respiration and circulation, and the removal of artificial teeth were advised before beginning anæsthesia.

In summing up his arguments, Mr. Braine said, (1) "It was well to avoid all anæsthetics which tend to depress the heart's action. (2) For short operations nitrous oxide is the best agent. (3) For longer operations, except where it is desirable to avoid hemorrhage, as in some eye operations, or where the cautery was used, ether answers perfectly. (4) The best time for operating is the early morning. (5) The nasal tubes are of little use. (6) Nitrite of amyl is the best cardiac stimulant."

In view of the frequency with which anæsthesia is practiced, and the danger attendant thereupon, such practical suggestions as these should be carefully considered and adopted.

New Publications.—Messrs. H. C. Lea's Son & Co., the well-known publishers of Philadelphia, announce that they will shortly issue the first volume of "The American System of Practical Medicine."

This work, when completed, will consist of five imperial octavo volumes, containing one thousand pages each, with illustrations. The work is the contribution of many pens, arranged and edited by Prof. William Pepper, of the University of Pennsylvania, assisted by Dr. Louis Starr, of the same institution. The list of authors and subjects is a guarantee that the work will come up to the highest requirements of the practitioner of medicine. The work will be sold by subscription, at the following prices per volume: Cloth, $5; leather, $6; half Russia, $7.

Messrs. Wm. Wood & Co., of New York, will shortly issue a new work, entitled "A Reference Handbook of the Medical Sciences." This work will consist of six or eight royal octavo volumes of eight hundred pages each. It will be edited by Dr. Albert H. Buck, of New York, and will embody contributions on a large number of subjects, from over two hundred of the best known writers in America and Europe, Such a work cannot fail to have a great value to the student of the medical sciences.

Book Notices and Reviews.

Pyuria; or Pus in the Urine, and its Treatment. Comprising the Diagnosis and Treatment of Acute and Chronic Urethritis, Prostatitis, Cystitis, and Pyelitis, with Especial Reference to their local Treatment. By Dr. Robert Ultzmann, Professor of Genito-Urinary Diseases in the Vienna Polyclinic. Translated by Dr. Walter B. Platt, F.R.C.S. (Eng.), Demonstrator of Surgery in the University of Maryland, Visiting Surgeon to Bayview Hospital, Baltimore. New York: D. Appleton & Co. pp. 98.

Those of the profession who are familiar with the works of Prof. Ultzmann will welcome this translation as constituting a real addition to our literature on genito-urinary diseases. It cannot be too highly recommended to the attention of the profession, not only on account of its scientific value, but also for the many practical suggestions regarding treatment to be found in the chapter on therapeutics. The translator is to be congratulated upon the excellent manner in which his work has been accomplished. The book is neatly and tastefully gotten up by the publishers.

BOOKS AND PAMPHLETS RECEIVED.

A Theoretical and Practical Treatise on the Hemorrhoidal Disease, giving its History, Nature, Causes, Pathology, Diagnosis, and Treatment. By William Bodenheimer, A.M., M.D. Illustrated by two Chromo-Lithographic Plates and thirty-one Wood-cuts. New York: Wm. Wood & Co. pp. 297.

A Text-Book of Hygiene, a Comprehensive Treatise on the Principles and Practice of Preventive Medicine from an American Standpoint. By George H. Rohé, M.D., Prof. of Hygiene, College of Physicians and Surgeons, Baltimore, etc., etc. Baltimore: Thomas & Evans. pp. 324.

A Manual of Bandaging. Adapted for Self-Instruction. By C. Henri Leonard, A.M., M.D., Prof. of the Medical and Surgical Diseases of Women, and Clinical Gynæcology, Michigan College of Medicine, etc., etc. With one hundred and thirty-nine Engravings. Second Edition. Revised and Enlarged. The Illustrated Medical Journal Co., Detroit, Mich.

Diphtheria; Its Sanitary, Preventive, and Local Treatment. By Jackson Piper, M.D., of Towson, Maryland. Baltimore: James Young. pp. 15.

Notes on the Opium Habit. By Asa P. Meylert, M.D., Member of the Medical Society of the County of New York, etc. Third Edition. Revised and Enlarged New York and London. G. P. Putman's Sons.

Home Again! A Synopsis of a Tour Abroad. By Edward Borck, A.M., M.D., of St. Louis, Delegate to the International Medical Congress, held at Copenhagen, Den. 1884. St. Louis: Chambers & Co. pp. 24.

Malformation of the Female Sexual Organs Resulting from Arrest of Development. By B. Bernard Browne, M.D., Prof. of Gynæcology and Obstetrics in the Baltimore Polyclinic and Post-Graduate Medical School, Prof. of Diseases of Women in the Woman's Medical College of Baltimore, etc., etc.

Transactions of the Medical Society of the State of Pennsylvania at the Thirty-fifth Annual Session, held at Philadelphia, May 14–16, 1884. Volume XVI. Published by the Society.

The Principles and Practice of Gynæcology. By Thomas Addis Emmet, M.D., LL.D. Third Edition, Thoroughly Revised. With one hundred and fifty Illustrations. Henry C. Lea's Son & Co., Philadelphia. 1884. Cushing & Bailey, Baltimore. pp. 876.

The Science and Art of Surgery. A Treatise on Surgical Injuries, Diseases and Operations. By John Eric Erichsen, F.R.S., LL.D., F.R.C.S., Surgeon Extraordinary to Her Majesty, the Queen, etc. Eighth Edition. Revised and Edited by Marcus Beck, M. S. and M. B., Lond., F.R.C.S. Volume I. Henry C. Lea's Son & Co., Philadelphia. 1884. Cushing & Bailey, Baltimore. Price: Cloth, $4.50; Leather, $5.50. pp. 1,124.

Elements of Surgical Diagnosis. By A. Pearce Gould, M. S. and M. B., Lond., F.R.C.S., Eng. Henry C. Lea's Son & Co., Philadelphia. 1884. Cushing & Bailey, Baltimore. pp. 589.

Intestinal Obstruction; Its Varieties, with their Pathology, Diagnosis, and Treatment. By Frederick Treves, F.R.C.S., with sixty Illustrations. Henry C. Lea's Son & Co. 1884. Cushing & Bailey, Baltimore. pp. 515.

Miscellany.

The Treatment of Retro-Uterine Hæmatocele.—In a paper published in a recent number of the *Archiv für Gynäkologie*, Dr. Paul Zweifel advocates more frequent interference with these effusions than has hitherto been considered good practice. It seems to us, however, that the facts he adduces do not strongly, if at all, support his contention. He advises incision per vaginam, under antiseptic precautions, followed by frequent washing out of the cavity in which the blood has been contained. He relates four cases of his own in which this practice was followed; three got well and one died. He quotes from other sources twenty-four cases treated by incision per vaginam, of which five died. In two of these cases death occurred by sudden collapse following the washing out which Dr. Zweifel recommends. As he thinks the washing out was not done in these cases in a proper manner, our author eliminates these two, and reckons, including his own, four deaths out of twenty-six cases, or a mortality of 15.3 per cent. In our view, however, the two omitted cases ought by no means to be lost sight of, for they prove that the washing out of such cavities is not a thing to be done with perfect confidence in its safety. Our own impression is that most cases do just as well without it. Dr. Zweifel then adduces a collection of sixty-six cases treated by puncture, with ten deaths, or 15.1 per cent.: a result much the same as that gained by the practice of incision. Bearing in mind the fatal cases of injection, puncture seems to be the safer practice. Lastly, Dr. Zweifel gives for comparison a collection of one hundred and twenty-nine published cases treated on the expectant plan, with a mortality of 18.4 per cent. But it must be remembered that published cases available for comparison contain an undue proportion of fatal cases, and of cases in which the hæmatocele discharged into a mucous tract; for it is only in such cases that (independently of treatment) the diagnosis is certain. It is familiar to every gynæcologist that small pelvic tumors, accompanied with the history and having the signs of hæmatocele, are very common, and generally get soon well, the mortality among such cases (of which the diagnosis, although not scientifically certain, is yet as sure as that of the cases calling for operation) being nothing like eighteen per cent. We regard Dr. Zweifel's figures, combined with daily experience, as confirming the old rule, not to meddle with hæmatoceles unless urgent symptoms, either of pressure or pyrexia, are present. We agree with him that, if we do anything at all, a free incision is best; but the subsequent washing out adds a new source of danger, and, if free exit for discharge be maintained by a drainage, is not required. If an India-rubber tube will not keep open, a glass one can be used.—*Lond. Med. Times.*

The Ideal Doctor.—1. He must be a careful and accurate, and at the same time a keen and quick observer of nature. 2. He must be able to connect his isolated observations, effect of rapid and at the same time trustworthy, processes of reasoning. 3. He must, in dealing with emergencies, endeavor to have always what the Greeks (and Dr. John Brown after them) called *agchinoia*—nearness of the *nous*, *i. e.*, presence of mind. 4. He must, as a surgeon or accoucheur, have much deftness of manipulation—manual dexterity, as we call it; a perhaps, still better, ambidexterity. 5. He must treasure in his memory and be constantly increasing from day to day, large stores of various reading in his own and other languages, in order that not only all past observations, but also that the vast field of scientific progress in its relation to his art may be constantly before him, or at least freely accessible when wanted. 6. He must be able to write, at least in his own native language, with vigor, compactness and lucidity. 7. He must have a soul above mere money-grabbing; must on no account degrade his profession into a trade; but must be, as far as possible to human nature, the disinterested friend, the companion, the good genius, I had almost said, of all his patients. 8. For this reason, if for no other, he must in every case have in him the distinctive essence of what is called a gentleman; and if his practice is, or is ever to be, among what are called the upper classes, he must be a gentleman not only in principle, but in detail; not necessarily what is vulgarly and falsely often styled a fine gentleman, but a gentleman in outward manner as much as in the inner spirit. 9. He must be a man endowed with a deep sense of moral responsibility, so as to beget confidence and unfailing trust in him on the part of his fellow-man. Responsibility, therefore, to them in the first instance; but underlying that and sustaining it as surely as the root and stem sustain the flower—a deeper and more latent responsibility to Him who is the source of all good, and therefore, of all moral principle and moral responsibility whatever.—Professor Gairdner.

Temporary Preservation of Post-mortem Specimens.—In the second Number of *The Asclepiad*, among the Opuscula Practica, Dr. Richardson describes a method of temporarily preserving specimens taken from the dead body. A wide-mouthed bottle, with a large stoppor, which is made to fit evenly by the use of a little glycerin, is filled with a mixture of common coal-gas and one drachm of ammoniated chloroform. The stopper is then tied down. Any part which is desired to be preserved is placed in a fold of soft muslin and gently pressed so as to remove superfluous fluid. The next point is to introduce the part enveloped in the muslin into the bottle without displacing more of the gaseous contents than necessary. The ammoniated chloroform is supposed "to prevent the breaking up of the water of the tissues," and the carbon monoxide of the coal-gas preserves the color of the specimen.—*Lancet.*

Treatment of True Pneumonia by the Cold Bath.—Two communications have been recently sent to the *Gazette des Hopitaux* by Dr. Chaumier, in which he strongly condemns the old treatment of pneumonia by drugs, blisters, emetics and bleeding. The author claims that statistics prove pneumonia to be more curable without drugs than with them, and that children always recover from pneumonia when drugs are withheld. He used the cold-bath treatment in fourteen children, all of whom recovered. His observations lead him to conclude that there is no danger from the bath in any stage of the disease. He gives a bath of ten minutes' duration, at from 82° to 90°, every two or three hours to an adult, and two or three times a day to a child. Each bath produces a lowering of the temperature of from two to three degrees, of the pulse from ten to thirty-two beats, and of the respiration from six to fourteen per minute. The *bruit de souffle* produced by the fever disappears, dyspnœa is decreased, and there is less thirst. The author is inclined to think that mortality may be lessened by the use of the cold bath, although he is ready to admit that his own observations concerned such cases only as would doubtles have recovered without treatment.—*Med. Record.*

As regards the moral capacities of the members of this profession, where is there to be found more self-sacrifice, more calm courage in the midst of constant danger, more earnest and incessant labor, more bowing down of the head and heart and

soul in care and anxiety for others? Every element or condition that tends to ennoble the moral faculties of man, to refine his feelings, to deepen his sympathies, to kindle his charity, to augment his self-abnegation and increase his care for others, is to be found in the daily work of the physician, just as much as every element or condition that can elevate and train his intellectual faculties is to be found in his daily studies. —*Ashe, Carmichæl Prize Essay.*

Medical Items.

Dr. J. Prosser Tabb was drowned in Gloucester County, Va., Dec. 13th. He was 62 years old.

Dr. Charles Clay, of Manchester, the Ovariotomist, has been stricken with paralysis, at the age of 83.

Dr. Grawitz, who recently declined the Pathological Chair at Bellevue, has been elected Professor of Pathology at the University of Greifswald.

A School of Biology was inaugurated in Philadelphia, Dec. 4th, in connection with the University of Pennsylvania, under the direction of Prof. Leidy.

Surgeon P. H. Bailhache, of the Marine Hospital Service, well known in this city from his connection with the Service here some years back, has been assigned to duty in Philadelphia.

Mr. Meredith, Knowsley Thornton's assistant, reports in the *Brit. Med. Journal*, fifty cases of ovariotomy done antiseptically (including the spray) during three years. The mortality was eight per cent.

Schweninger, it is said, has not had a single student at his Clinics since he entered upon his duties as Professor of Dermatology at the University of Berlin. He is also entirely ostracised by his colleagues.

Dr. J. G. Thomas, of Savannah, one of the members of the General Committee of Organization of the Ninth International Congress, died of acute pneumonia, contracted dusing his attendance upon the meeting for organization recently held in Washington.

Dr. Frederick A. Mahomed, the author of a number of valuable papers relating to kidney diseases, died on Nov. 22d, at the early age of 35. Dr. Mahomed was one of the most distinguished of the younger members of the profession in England, and his death is a great loss.

Dr. Magnus Simpson, youngest son of of the late Sir James Y. Simpson, died recently in Edinburgh, æt. 32, of heart disease. He studied ophthalmology, but his health did not permit him to practice.

Prof. Fossagrives, who held the Chair of Therapeutics at the Montpellier Medical School, died recently of cholera. He was the author of several standard works, the most important being a Treatise on Applied Therapeutics, in two volumes, which took the prize at the Paris Academy.

The result of the recent Commission of Inquiry is that compulsory vaccination is to be retained in Germany. Vaccination with human lymph is to be gradually given up and animal lymph introduced instead. State institutions will be established in various places throughout the Empire in order to supply the latter.

Charges were recently brought against Dr. Fordyce Barker, President of the New York Academy of Medicine, by Drs. Flint, Jr., Bozeman, Arnold, Purple and others, for swearing falsely that he was a graduate of the Paris School of Medicine. An examination of the charges by the Ethical Committee of the Academy resulted in his unanimous acquittal.

M. Laborde reported to the Paris *Société de Biologie*, Nov. 22d, experiments with the muriate and sulphate of cocaine which show that this agent injected under the skin, or into the veins, in the dose of one-fifth to one-third grain, produces first hyperasthesia, often even convulsive pnenomena, an epiliptiform attack, mydriasis and complete analgesia.

Dr. Henry Gibbons, Sr., died recently in San Francisco, Cal., in the seventy-sixth year of his age. He was born in Wilmington, Del., and graduated from the University of Pennsylvania in 1829. He moved to California in 1850, where he soon established himself in his profession and achieved a high position. He established, and for a number of years successfully conducted the *Pacific Medical and Surgical Journal*. He was one of the best-known physicians west of the Rocky Mountaing.

Official List of Changes in the Medical Corps of the U. S. Navy during the week ending December 20, 1884.

Kindleberger, D., Medical Inspector, detached from " Hartford, and placed on sick leave.

Original Articles.

THE LIBERATING OF THE RING FINGER, IN MUSICIANS, BY DIVIDING THE ACCESSORY TENDONS OF THE EXTENSOR COMMUNIS DIGITORUM MUSCLE. *

BY WM. S. FORBES, M. D., OF PHILADELPHIA,

Senior Surgeon to the Episcopal Hospital. Demonstrator of Anatomy at Jefferson Medical College.

When the middle finger and the ring finger are brought down by the flexor muscles, and their balls are held down firmly against the keys of a musical instrument, as in performing on a piano, for the purpose of producing continuous sounds, and at the same time it should be necessary to extend and then to flex the ring finger in order to produce accompanying sounds, it will be found that in the still flexed position of the middle and little fingers, the ring finger can be but very slightly extended. Its complete extension, without operative interference, can only be brought about by long-continued exertion in practice, when elongation of certain accessory, but restricting, tendons is made by nutritive change.

To explain the cause of the inability to extend at once, completely, this ring finger, and to demonstrate the way to remove this cause, by a surgical operation of simple moment, is the object of this paper.

In the dorsal aspect of the metacarpal zone in man, dissection shows that the tendon of the extensor communis digitorum muscle that goes to the ring finger gives off a slip on either side, one of which goes to join the extensor tendon of the middle finger and the other to join the extensor tendon of the little finger. These two slips are known as the lateral vincula or *accessory* tendons. Now, while the middle and little fingers are held in a flexed position, these accessory tendons, by virtue of their attached extremities, hold in check the extending power of the muscular fibres operating upon the tendon of the ring finger, and thus this finger is restricted in its function of extension to a very limited degree.

These accessory tendons are sometimes found in one hand and not in the other. They exist more frequently in the right hand than in the left. Now and then the extensor tendon of the ring finger splits at the point of departure of the accessory slips and then reuniting leaves a buttonhole appearance, and again these accessory slips are entirely absent.

In 1857, Mr. J. D., a young musician and a performer on the piano, consulted me in regard to his inability to *lift up*, as he expressed it, the ring finger of his right hand while the middle and little fingers neighboring were held flexed on the keys of his piano.

This restriction did not exist in the ring finger of his left hand; with it he had no trouble. I explained to him the presence of the accessory tendons in his right hand, with their restricting power, and told him of their probable absence in his left; they could be distinctly felt in his right hand, I could not observe them in the left.

At his desire I performed the operation of subcutaneous tenotomy on the tenth day of November of that year. An incision less than a quarter of an inch in length was made through the skin and facia just below the carpal articulation of the metacarpal bone of the ring finger, and above the radial accessory slip of his right hand and parallel with, and on the radial aspect of, the extensor tendon of the ring finger.

A narrow, blunt-pointed bistoury placed in this incision, with its handle depressed and its blade flatwise, was carried beneath the accessory slip and down as far as just a little above and between the knuckles of the ring and middle fingers, where its blunt point could be felt beneath the skin. The bistoury was now turned with its sharp edge towards the skin, and the middle finger strongly flexed and the ring finger extended, so as to make tense the accessory slip, when with a gentle sawing motion the slip was at once severed; the bistoury, turned flatwise, was now withdrawn through the same opening by which it entered. The accessory slip on the ulnar side of the extensor tendon of the ring finger was divided in a similar manner immediately afterwards by a distinct incision through the skin and

* Read before the Philadelphia County Medical Society, November 12, 1884.

fascia on the ulnar side of the extensor tendon of this finger. Not a quarter of a drachm of blood was lost in the two operations. A small piece of adhesive plaster was placed over each incision and a figure-of-8 bandage was carried around the wrist and hand, leaving the thumb free, and kept on for two days, when the patient was asked to perform on his piano in order to keep the cut extremities of the accessory tendons apart. A slight swelling of the parts existed for less than a week. The liberation of the ring finger was complete. The ball of the finger could be elevated an inch farther from the plane of the hand, and my patient expressed his gratification at the extended and great facility with which he could use this ring finger on the keys of his piano.

In 1881, Mr. Richard Zeckwer, the accomplished professor and director of music in the Philadelphia Musical Academy, called on me and asked me whether I could not cut these accessory tendons. He stated that if they could be cut in some of his students in music, that he was sure much time would be saved and their advancement in music greatly accelerated.

Mr. Zeckwer had been well taught the the anatomy of the hand, in Leipsic, where he was educated in music, and was well aware already of the restraining force of these tendons. His views were right, in my opinion. He brought to me a young man whose left ring finger was very much restricted and the tense accessory tendons could be distinctly felt. At the young man's desire, I operated at once, and on dividing the tendons of the fingers he could lift this finger from the plane of the hand an inch higher than before the operation.

Since 1857 I have divided these accessory tendons for the purpose of liberating the ring finger in fourteen persons, and in nine of these the operation was performed on the tendons of both hands at one sitting. I do not think at any one of these operations half a drachm of blood was lost. In not one of them did any accident follow the operation. The issue in all of them was successful.

In two persons who came to my office together, strangers from a distance, I performed this operation on the two hands of each of them in the presence of my friend, Dr. Addinell Hewson, Jr. These two patients said, with emphasis, that there was not only relief in using the ring finger, but there was also an absence of exertion, which, before the operation, was constant and forcible along the back of the forearm and hand.

It will be observed that in this operation the totality, the complete sum of the power, of the extensor tendon going to the ring finger is left unimpaired. Nor does the operation lessen in the least the power of the common extensor muscle to extend the neighboring fingers.

The question may be asked, then, of what use are these accessory tendons in man? As far as I am capable of observing, they are entirely vestigial. Just as we may believe that the plantares are vestigial muscles.

This brings us to look into the comparative anatomy of these accessory tendons, and to examine the entire muscular anatomy of the hand. Prof. Owen thus writes, in regard to the flexor and extensor muscles in the hand of mammals:* "The deep and superficial flexors of the fingers are distinct, but a remnant of that blending which exists in most lower mammals may be seen in the short connecting tendon which, in the aye-aye, passes from the ulnar belly of the 'flexor sublimis' to the division of the 'flexor profundus,' giving off the tendon to the middle fingers. The fleshy part of both flexors, but especially the deep one, is continued nearer to the hand in *Lemuridæ*, and most other *Quadrumana*, than in man, thus enabling the muscles to continue their action as finger-benders when the hand itself is flexed. . . . The 'flexor brevis,' the 'abductor,' the 'adductor,' and 'opponens pollicis,' are present in the chimpanzee and gorilla, as are likewise the 'extensor longus' and 'extensor brevis.' In the orang these muscles begin to be confounded; in most lower *Quadrumana* they are blended together. The homologue of the 'extensor indicis' of man bifurcates, and sends a tendon both to the index and medius digit; the homologue of the 'extensor minimi digiti' likewise splits, and sends a tendon also to the annularis; so that, while in man the index and minimus only have two extensor tendons, all four fingers have them in most *Quadrumana*. The hand is thereby the stronger as a sus-

* Owen, Comparative Anatomy and Physiology of Vertebrates, vol. iii, p. 53.

pensor of the body from a bough."

In all felines we find that, although lateral motion in the hand is restricted, flexion and extension are very forcibly made. Thus in the cat we find not only a common extensor, but also a proper extensor to the index, middle, ring and little fingers. The proper extensors to the index and to the little fingers have their analogues in man in the extensor indicis and the extensor minimi digiti. In man the common extensor tendon of the ring finger gives off lateral branches; in the cat it does not, for here we find a perfect additional organ. We may believe then that the accessory tendons, going off from the extensor tendon of the ring finger in man, are the vestigial remains of muscles which in the lower animals are developed and perfect organs.

The perception of pleasure in the equality of sounds is the principle of music. If the power of producing the equality of sounds is restricted by the vestigial accessory tendons, they should be divided, especially as this division is so easily accomplished.

I would divide them just as I would divide the tendons of the internal rectus in certain cases of squint, in order to extend the range of vision.

In examining the muscular anatomy of the hand, it will be found that flexion and extension are produced not only by those muscles which especially make these motions, but by all those muscles whose tendons pass beyond the radio-carpal articulation. Flexion of the wrist is produced by the radial and ulnar flexors of the carpus, and is aided by the flexors of the fingers, when the action of those muscles of the fingers is either completed or is opposed by any resistance, as when the over-extended hand is pressed against a surface in pushing, or in the support of the body. Extension of the wrist, in a similar manner, is accomplished not only by the three muscles specially devoted to that function—the extensor carpi radialis longior and brevior, and the extensor ulnaris—but also by the extensors of the fingers.

To ensure the efficient action of the long extensor and flexor muscles of the fingers it is necessary that there should be simultaneous action of the flexors and extensors of the wrist respectively; for the wrist-joint must be fixed backwards by its extensors, in order that the long flexors of the fingers may act. And the wrist must be fixed forwards by its flexors, in order that the long extensors may act upon the fingers.

The flexor communis digitorum sublimis and the flexor profundus bend respectively the second and the third phalanges of the fingers, while the extensor communis extends the *first phalanx*. The four lumbricales, on the other hand, and the seven interossei muscles have a double action, in consequence of their insertion into the lateral expansions of the extensor tendons, and some of the interossei directly into the base of the first phalanges. This action consists, first, in the flexion of the fingers at the metacarpo-phalangeal articulations, and, second, in extension of the second and third phalanges. The lumbricales and interossei,* therefore, are antagonists to both the long flexors and to the long extensor. This partial and combined action of the long and short muscles upon the fingers has been well known for some time, especially as regards the lumbricales; but it has recently been confirmed and elucidated, as regards the interossei, by the electro-physiological experiments and pathological observations of Duchene.†

With respect to the interossei, it is further to be observed that, besides being *flexors* of the *first* phalanges, by virtue of their insertion into the base of these bones, and at the same time *extensors* of the *second* and *third* phalanges, by virtue of their further insertion into the lateral expansions of the extensor tendons, they severally exercise an abducting or adducting action on certain fingers, or direct them away from or towards the middle line of the hand, according to the places of their respective insertions; and thus the four dorsal interossei are abductors of the index, middle, and ring fingers, and the three palmar interossei are adductors of the index, ring, and little fingers respectively.

While other professions are laboring, organizing, scheming, for their own advancement, and for the establishment of their power over society, ours has so completely forgotten its common interest in individual sacrifice, that to this day it remains, as has been well described for all practical purposes, a disorganized rabble.—*Asche.*

---

* Quain's Anatomy.

† Duchene, "Physiologie des Mouvements."

A CASE OF HYPOSPADIAS SIMULATING HERMAPHRODISM; WITH SPECIMENS.

BY W. T. COUNCILMAN, M. D., OF BALTIMORE.

The case to which I wish to call your attion to-night is one of a high degree of hypospadias simulating hermaphrodism. The history of the case is briefly as follows:

J. B., aged 26 years, sailor by occupation, was admitted to Bayview Asylum, April 26, 1884. He was born on the Island of Malta; has father was an Englishman and his mother a Maltese. He had two brothers, both of whom are married and have families, and three sisters. At the date of admission he had general anasarca; suffered much from dyspnœa and gave all the clinical evidence of Morbus Brightii. While in the hospital his belly was tapped several times and a large amount of water withdrawn at each tapping, giving him relief from his most threatening symptoms. The whole time while in the hospital a distinct diastolic murmur was heard over the base of his heart. The heart seemed hypertrophied. His condition gradually became worse, and he died on Dec. 2d. The post mortem examination gave the following: Body, 65 c. m. long, pale, somewhat emaciated; the lower extremities œdematous, and the abdominal cavity distended with fluid. Eyes brown, pupils dilated, hair straight, abundant and of dark color. The hands and feet were small; hips, broad and rounded; chest, small. The face was smooth, with exception of a few long hairs on the upper lip and cheeks. In the abdominal wall, two inches below the umbilicus and in the median line a puncture. There was a slight growth of hair upon the pubes and in the axillary spaces. Commencing at the symphisis and extending down to within three c. m. of the anus were two large folds of integument. These folds were distinct at their origin and rounded off together above the anus. At about their middle third two small movable masses of about the size of a bean could be felt. On closer examination these masses could be separated into two parts. A pendulous body, very similar to a diminutive penis, hung from the pubes down between the described folds of integument. At the extremity of this organ was a well-shaped glans penis; the anterior measurement of this organ, from its commencement to the glans, was six c. m.; the inferior measurement, three. On raising the body, a groove was seen extending down from the glans to a round orifice in the depression between the folds of integument. This opening led into the bladder. The examination of the internal viscera showed œdematous lungs, hypertrophied heart, fibrinous peritonitis, white kidney, œdematous meninges and brain.

The man had suffered from malaria for some time previous to his entry into the hospital, and his spleen showed the usual chronic enlargement, induration, and pigmentation. His liver was also pigmented, connective tissue in it slightly increased.

The bladder, rectum, perineum and soft parts front of the pubes were removed together, and Prof. Michael was kind enough to make the dissection. The base of the bladder was first examined. The prostate gland was present, but was very diminutive. The right vesiculæ seminales and vas deferens, small but quite distinct. Vesiculæ contained a very small amount of clear fluid which, on microscopic examination, was shown to contain a very small quantity of epithelium filled with pigment granules. No spermatozoa were found. The left vas deferens and vesiculæ, smaller and less distinct than on the right side. The right testicle with cord removed and dissected, showing tunica vaginalis, epididymis, globus major and minor, and body of testicle occupying their normal relations to each other. The testicle was very diminutive, measuring, in its long diameter, fifteen millimeters, and in its transverse ten millimeters. The epididymis was of proportionate size. The left labial fold was opened by incision as for castration, revealing a testicle which was somewhat smaller than the right organ. Microscopic examination of the testicle after hardening in alcohol, showed a few of the seminal tubules well developed, but in general they were small and imperfectly developed. The seminal vesicles were of a perfectly normal structure. The result of the examination showed the case to be one of *pseudo-hermaphrodismus masculinus externus*, with imperfect development of the sexual glands. The general type of the body approached

* Read before Clinical Society of Maryland, Dec. 19, 1884.

more nearly that of the female than male, as evidenced by the small hands and feet, broad hips, small chest, lack of beard, etc. The pelvis, which I will show, seems in some respects more like a female than a male.

From statements of the patient, his instincts were entirely those of a male. He had a desire for, and says he often effected, coitus, which was complete, although there was always some complaint from the other party to the act about the small size of his organ. He affirmed further, that he often had lascivious dreams, with emission of semen. The penis, he says, became perfectly erectile. It is rather difficult to believe these statements of the patient, in view of the results of the examination. Before I pass the specimens around I wish to say one word about the development of the genitalia which, I think, will render the understanding of the condition more easy.

In the second month of intra-uterine life the pedicle of the allantois divides into three portions, a middle spindle-shaped part, which becomes the urinary bladder; a part runs from this into the cloaca, which may be called the urethra; and an upper portion which afterwards becomes the middle ligament of the bladder. The two wolfian bodies empty into this allantoid pedicle. These wolfian bodies, represent the kidney of the embryo. On the medium side of the wolfian bodies the genital gland, which, in course of time, becomes either the testicle or ovary, develops. At the same time there is developed on the anterior side of the wolfian body a long, thin fold which, afterward, becomes a duct, known as Müllers duct. These ducts of Müller become joined as they descend to make a single duct. Thus the lower end of the primitive urethra has inserted into it three ducts which are united into a single cord. The part of the pedicle which we have spoken of as the primitive urethra, thus becomes divided into two parts, one above, the true urethra, and one below, known as the sinus urogenitalis. At about the tenth week a division grows into this cloaca which separates the rectum off from the urogenital sinus. This projection forms the perineum.

In the other figure, which represents the section through the inferior extremity of a rabbit embryo, we see the cloaca and the other parts well shown. Concerning the development of the outer genitalia, at about the sixth week a small eminence appears which is known as the genital eminence, and on each side of this a fold of skin known as the genital folds. On either side of urogenital sinus there develops two small ridges extending from the sinus to the end of the genital elevation. The genital folds afterwards become, respectively, the labia majora of the female and the scrotum of the male. The genital ridges unite to form the male urethra closing in the urogenital sinus. In the female they form the labia minora. The genital elevation becomes the penis of the male and the clitoris of the female. In the case which I have the pleasure of showing to-night we have the open urogenital sinus:

IN MALE.

Genital Gland, Testicle.
Wolfian Body, Vas Aberans.
Wolfian Duct, Seminal Duct.
Müller's Duct, Utriculus Masculinus.

IN FEMALE.

Genital Gland, Ovary.
Wolfian Body and Duct, } Parovarium or Organ of Rose Müller.
Müller's Ducts, } Uterus, Fallopian Tubes and Vagina.

A SIMPLE BUT UNIQUE METHOD FOR REMOVING CERTAIN FORMS OF FOREIGN BODIES EMBEDDED IN THE EYE.

BY E. MEIERHOF, M.D., BALTIMORE, MD.

There are certain forms of foreign bodies embedded in the eye within easy reach of removal which do not admit of the ordinary methods employed for the purpose. Every one is familiar with the device of wrapping or twisting absorbent cotton on a splinter of wood, such as the common tooth-pick, an idea which suggests itself to the merest tyro; the necessary material being generally at hand, and seemingly little risk incurred in the procedure. Yet there are objections which can be properly urged against this method, due to some risk in causing certain forms of foreign bodies, such as fine splinters having the properties of brittleness with sharp or irregular points,

which were previously superficial, to become embedded. As long as the particle is confined to the palpebral and ocular conjunctivæ there is practically no danger, but on the cornea it is quite different. Any one who has seen many foreign-body cases among mechanics, and others, is made familiar, in a very practical way, with the vulnerability of the conjunctival epithelium covering the corneæ, and also its deeper structures, although histologically the corneal tissues proper are shown to be quite tough and unyielding, which is no doubt quite true of experiments in testing its toughness by pricking or sticking the laminated corneal structures at right angles to their surfaces; but if we attempt the experiment so as the point of the instrument passes in a more parallel direction to the surfaces of the corneal lamina, it is found much easier of frustration. This I have often verified on the eyes of man and the lower animals.

Dr. C. R. Agnew, of New York, is said to be quite fond of the cotton-mop for removal of foreign bodies; others, especially Dr. Knapp, have tried it, but generally use the triangular-shaped spud, as being, after all, more safe and scientific.

Now, occasionally we meet with a class of cases which do not admit the use of the spud on account of the peculiar position in the embedded structures of the foreign body. It was such a case as I am about to describe which I had the opportunity of observing at the New York Eye and Ear Hospital, in the service of Dr. P. Callen. The following is a description of the case: A boy about eleven years of age presented himself for an injury to his eye, caused by a companion having thrown, the day before, a burr of the thistle weed such as grow on the commons and outskirts of the city. The juvenile term for the burr is "nigger lice," as they are aimed at the head and sometimes are entangled in the wooly structures. It was the spine of such a burr which was found in the boy's left eye, it having gone through the cornea, the depth of the anterior chamber and iris, and just touched the lens capsule, producing slight cloudiness in the vicinity of contact. The eye did not seem to indicate a great amount of irritation; there was some injection of the conjunctiva. He appeared to suffer little pain, not as much as one might expect from a foreign body piercing the iris, and either tearing that delicate structure or causing some dragging on its peripheral attachment, when the pupil dilated and contracted; for when the boy presented himself he had the eye uncovered, thereby allowing the light to exert its influence on the iris.

When the case was first seen it seemed to appear a very easy matter to seize the minute protusion through the lower nasal part of the cornea with a pair of fine forceps, but after many futile attempts with various appliances, it was decided to make a corneal section, and adopt the usual method of seizing the thing with a pair of forceps and attempt its removal in the manner deemed safest. Just before attempting this method, the expedient of passing a fine needle on each side of the offending body to raise it up sufficiently to be seized with a pair of forceps, was successfully tried; whereas, in the previous effort it was impossible to grasp the end. After the operation atropine was put in the eye. After a few days the irritation ceased, and the opacity on the lens capsule appeared to diminish.

Cases somewhat similar to this one may come under the care of any practitioner, and the simplicity of the procedure recommends itself especially on that account. Muriate of cocaine, which was used in this case, was not entirely successful.

REMOVAL OF UTERUS AND OVARIES BY ABDOMINAL SECTION, FOR FIBRO-MYOMATA. DEATH, ON TWELFTH DAY, FROM SEPTICÆMIA.*

BY J. M. BARTON, M. D., OF PHILADELPHIA.

Mrs. K., æt. 31 years, was brought to me, last September, by Dr. M. B. Dwight, of Jersey Shore, Pa. She was very pale, the face and lips being entirely colorless; indeed, the appearance of the patient suggested the presence of malignant disease. She had to be carried to her room on her arrival in this city. She had been losing more blood than she should for several years, and for several months she had had a

* Read before the Philadelphia County Medical Society, December 17, 1884.

daily loss, frequently in quite large amounts, and was losing strength rapidly.

On examination, a large, hard, smooth and freely movable tumor, evidently the uterus, extending three inches above the umbilicus, was found; by the sound, Dr. Dwight's diagnosis of a sub-mucous fibroid, with extensive uterine attachments, was readily confirmed.

As the uterus was entirely out of the pelvis, as the attachments of the tumor occupied more than three-fourths of its entire circumference, and as the remaining uterine wall was much thinned, removal by the vagina was plainly impossible. I advised extirpation of the ovaries, if accessible, or of the entire uterus, if, on exploration, it appeared preferable.

The patient returned to her home, as she preferred to have the operation performed there, to which I agreed, as I considered the mountain air much more favorable for operation and after-treatment than the wards of a general hospital.

On September 30th, I visited Jersey Shore and removed the growth, assisted by Drs. Dwight and Cline, of that place, Drs. Detweiler and Youngman, of Williamsport, Dr. Armstrong, of Lockhaven, and Dr. Orville Horwitz, of Philadelphia.

Thorough antiseptic precautions were taken, the hands of the operator and assistants were washed in carbolic-acid solution, all the instruments and ligatures were immersed in a similar mixture, the sponges were washed in a warm solution of the same acid, the abdomen of the patient was washed first with turpentine, then with soap and water, and lastly with carbolic-acid solution.

I made an incision through the abdominal wall, midway between the umbilicus and pubes, about two and a half inches long, through which I readily drew the right ovary; the left, however, could not be reached. Finding the uterus free from adhesions, and movable, we decided to remove it. I increased the incision until it ran nearly from ensiform cartilage to pubes, carefully checking all hemorrhage by forceps and catgut ligatures before opening the peritoneum, the uterus was readily lifted from its bed and placed upright, the left broad ligament was attached posteriorily and the left ovary laid against the spine, showing that it could not have been reached through the original incision. The intestines were held away from the uterus and supported by large, flat sponges, wrung out of warm carbolic-acid solution. The broad ligaments were tied in sections with carbolized silk and Thomas's large clamp placed upon the neck of the uterus.

Surrounding the parts with sponges, to prevent blood entering the peritoneal cavity, into which so far none had escaped, the uterus and both ovaries were rapidly removed; there being but little tension on the pedicle we decided to treat it outside.

The stump was trimmed so as to leave but little projecting above clamp, it was transfixed by a large pin and was seared on its cut surface by the actual cautery, the wound was closed by the interrupted suture introduced from within in the usual manner, it was not found necessary to make the "toilette of the peritoneum," as, thanks to the care of my assistants, no blood had been allowed to enter that cavity, and indeed but little was lost during the entire operation.

The uterus was seven inches in diameter and nearly a sphere, it was occupied by a single fibro-myoma, which was attached to the entire uterine walls, with the exception of a narrow channel about two inches wide, running from neck to fundus: on section, it presented the usual appearance of such growths, except in its centre, where it appeared to have undergone sarcomatous degeneration; this suspicion was subsequently confirmed on microscopical examination.

The after-treatment of the case was in the hands of Dr. Dwight, from whose very complete notes I take the following points:

The evening of the operation the temperature rose to 102·5°, the pulse to 120; under opium suppositories and occasional hypodermics of morphia the patient was quite comfortable; she took nothing whatever into the stomach, except small quantities of hot water, and had no vomiting. On the second day the thermometer arose to 104°, the maximum temperature observed.

On the third day she took some barley-water and in the evening some beef-tea, the general condition being improved and improving still more on the fourth day.

On the fifth day (Oct. 4) the bowels were moved by an enema; opium stopped; beef-tea, brandy and warm milk were taken freely; the patient was quite comfortable.

On the sixth day (Oct. 5) patient rested well during the night, takes warm milk

every three hours; pulse stronger, 120; temperature 101°; patient looks quite bright; natural movement of the bowels.

The notes of the seventh, eighth and ninth days are almost identical with the last one read, except that stitches were removed, and on the ninth day there was considerable pus coming from wound, and some swelling of the right parotid gland increased; there were evidences of systemic poisoning; and on the evening of the eleventh day she died.

At the autopsy, there was no inflammation of intestine, there was no pus found in lungs, liver or kidneys, though there was some in the abdominal cavity—this had probably entered a day or two before her death, and from it the blood-poisoning, which proved fatal, arose.

Society Reports.

REPORT OF THE PHILADELPHIA COUNTY MEDICAL SOCIETY.

DISCUSSION ON CUTTING ACCESSORY TENDONS EXTENSOR COMMUNIS DIGITORUM.

Dr. John B. Roberts, in opening the discussion, said: I have been greatly interested in hearing the account of the operation given. Since student days it has been in my mind, but I never happened to be called on to perform it. It was then taught as advisable and looked on as justifiable, and I now know that this suggestion must have come from Dr. Forbes. I have often tried to figure out a reason for these slips, and the disposition has been to regard them as analogues of structures found in lower animals, as Dr. Forbes holds. We have special extensors for the index and little fingers, and I have seen, on rare occasions, a special extensor for the middle finger, but I have never heard of a special extensor for the ring-finger.

The remarks on white fibrous tissue are interesting. The actions of this tissue are most important in holding the various organs of the body in place. It is at times, however, a surgical disadvantage, as, for instance, in the case of abscesses where the pus being confined by the density of this tissue does harm by more or less extensive burrowing. In binding down tumors and thus causing pain by pressure upon the nerves, and in causing suffocative pressure in bronchocele, it also demands operative interference. We can often relieve pain and asphyxia caused by pressure of this tissue by free incisions made subcutaneously or openly.

I shall be glad to hear further as to the time-test of these cases; and also whether the uncut tendon is made more pliable by actual stretching after long months of piano practice. It would seem to me that there was no stretching of this tendon possible, but that practice caused only a lateral movement of the contiguous tendons and thus permitted a greater freedom of motion in the finger. If this increased motion is possible, then how much time is gained by the operation? The operation itself must be a very simple one, and there should be very little danger of the tendinous bands uniting again.

Dr. H. A. Slocum: As there will probably be many ladies undergoing this operation, a pertinent question is: How much of a scar does it leave?

Dr. De Forest Willard: Some years since I heard that this operation had been performed for pianists, but did not know the exact details of results desired until this evening. The only danger would be that too deep a cut might divide fibres of the dorsal interossei, muscles which are of especial service to the musician, since extension and flexion of the first phalanx are important actions. These accessory tendons, as seen in the dissecting-room, are sometimes variable in their position, but the operation seems simple, and from the excellent results which I am accustomed to secure by subcutaneous divisions of fasciæ and tendons, I am inclined to favor the procedure of the lecturer.

Dr. Shakespeare: In connection with Dr. Forbes' incidental reference to Wickersheimer's preservative fluid, I would like to ask him if he has had any success in its use. I have myself made trial of it, as made here, after the formula published by the Government, and have, in every instance, failed to get good results, when using the fluid as an injection. I do not know of any successful results out of Germany, and do know of many failures. The suggestion has been made that there is a

secret yet held back by the inventor. On the contrary, with the fluid for immersion, moderately successful results have not been very difficult to obtain.

Dr. H. H. Smith: This operation, and the advantages to be gained by a free use of this finger, are both altogether new to me. As Prof. Zeckwehr is present, I hope he will state its value to the pupil, and whether it is better than the ordinary ring and elastic cords used by beginners.

Dr. O'Hara: I think it odd that no mention has been made of females being operated on for this condition. Is it possible that a vestigial condition remains with man, and woman does not share it? There are so many more women than men playing upon the piano, it would appear that the ring-finger was freer with them than with men.

Prof. Zeckwehr, speaking by request of the Chair, said: Pianists find great difficulty in performing, owing to their inability to extend the ring-finger. It takes a long time to remedy the difficulty to any extent by practice. With the palm down it can be raised but a short distance. The natural strength of this finger is not so great as that of the others. My pupil, on whom Dr. Forbes operated, gained in a quarter of an hour what I had not accomplished by twenty-five years' practice; before the operation he could raise the finger a quarter of an inch—after it, an inch and a quarter, a gain of a whole inch in a few minutes. I surely think the time gained a great advantage to piano pupils.

Dr. Carl Seiler: I am not a practical musician, but would ask if there was a great improvement in touch to be gained by this operation. I have noticed in what might be called one school of musicians, that the motion from the fingers was taught, while another taught motion from the wrist. The question is æsthetic: Can we gain a better touch by severing these bonds?

Prof. Zeckwehr: I never heard of the method of playing from the wrist. All musicians play from the knuckle-joints, keeping perfectly quiet wrists.

Dr. Seiler: Many musicians play from the wrist, and by that motion harshness is done away with and greater flexibility attained.

Dr. Blackwood: In organ-playing lateral movement of the fingers is necessary as well as extension. Does the operation increase the abduction and adduction movements? Experience has shown me the advantage of such mobility, particularly when the same hand is occupied in playing chords on two different manuals at one time, as, for instance, the 1st, 3d and 5th on the great and choir.

Dr. Forbes, in closing the discussion, said: In regard to the scar, I examined one of the patients to-day, and the sear could be scarcely seen. It should be distinctly understood that the cut necessary for the operation is but little longer than the width of a match. By means of a blunt knife to cut the tendon, and making the tendon tense, nothing else need be cut. From the first I performed this operation with a tenotome, but I received a letter from a gentleman at a distance, who said he had cut his own tendons with a razor. Dr. Willard spoke of cutting the dorsal interosseus muscle. If he does not carry the incision beneath the investing sheath, he will not touch the muscle. You *may* cut the nerve to be found here next to the skin, but a dull knife avoids this by *shoving* the nerve before it. Dr. Allen spoke of encountering membranous bands on the tendons. I would cut tendons and bands at once. The patient should play at once on the piano after the operation, and if any bands remain they should be cut by reintroducing the knife. Both tendons are cut at one sitting. Dr. O'Hara was struck by the absence of the mention of women, considering their great activity as pianists. In fact, one patient alluded to was a woman. It may be that their joints partake of the greater mobility of their nature, and are less rigid. I have certainly found that these ligaments do not obstruct their playing on the piano so much as in men.

If the principle in music depends on the equality of sound, and these bands interfere with the development of this equality, I see no reason why they should not be severed.

This operation, of course, cannot lessen lateral motion.

As to elongation of tendons, this can be only by nutritive change. There is no elasticity in white fibrous tissue; sometimes it appears to elongate, but this is merely by lateral movement of fibres. This rigidity is the greatest value of white fibrous tissue.

In regard to Wickerscheimer's fluid, I have had a great deal of difficulty in its

use, and thought he used some other ingredient in that imported, not mentioned when he sold his secret to the naval officers representing the U. S. Government. If, however, it is slowly injected in the preparation previously immersed in water, and then immersed in the prepared fluid and kept entirely immersed, sometimes it does well. The best quality of glycerine should be used.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD DEC. 22ND, 1884.

(*Specially Reported for the Maryland Medical Journal*).

The Association was called to order at 8.45 P. M., by the President, Dr. E. G. WATERS. There were twenty-four members present.

Dr. Gibbons related the following case: About middle of last June as a lady was rocking her baby, while sewing, she felt a sharp pain on the inner side of the thigh. The next day there was a small blue spot, with a great deal of pain. Sometime afterward Dr. G. was called in; he cut down, and found the needle. It had been in the thigh about five months, and had only moved twelve or fifteen inches.

Dr. Smith thought it was curious that it had not moved farther in that length of time.

CONGESTION OF THE LUNGS FROM HEART FAILURE.

Dr. Gibbons related the following case: Was called two weeks ago last Friday, about 2 o'clock in the morning, to see a stout, hearty man, who had been taken with stertorous breathing. His lips were blue and pulse feeble, thought he would certainly die; gave whiskey and digitalis, tied up patient's arm to bleed; the blood flowed very sluggishly, the veins would hardly fill. Dr. G. thought he removed about a half pint of blood, the patient improved soon after.

Dr. Beidler asked why he first stimulated and then bled.

Dr. Gibbons said he first stimulated, to stimulate the heart's action; bled, to remove excessive congestion.

The committee appointed to investigate and report to the Baltimore Medical Association, on the two fœtuses, exhibited by *Dr. G. Lane Taneyhill* before the Association, on the night of October 13th, 1884, supposed by him to be a case of superfœtation, made their report as follows: "Your committee would report that they have carefully examined the pathological specimens at two prolonged meetings, since they were exhibited at this Society, and, after exhaustive debate and a canvassing of the whole subject, regret that they can not be more definite in their statements.

Since the reading of the paper before this Association the lady has died, and a post-mortem has been made by *Dr. B. B. Browne*, who reported to the committee as follows: 'Post-mortem thirty-four hours after death: abdomen swollen and tympanitic; no evidences of peritonitis; uterus enlarged, swollen and flabby; the male sound introduced into the vagina, passed through the fundus without pressure. The interior of the uterus measured about three and a-half inches in the vertical diameter, and two and a-half inches in transverse diameter. The walls were in a state of fatty degeneration. On the posterior surface, near the right cornu of the uterus, the remains of placental attachments could be distinctly made out. The right Fallopian tube was enlarged to about half an inch in diameter, it was highly congested and of a dark purplish blue color. The left Fallopian tube was open for about an inch from its fimbriated extremity, but from this point to the uterus was completely closed. The left ovary was completely atrophied. This condition of the tube and ovary had the appearance of being of long standing.'

The committee is unable to say whether it was or was not a case of superfœtation, while the result of the post-mortem, as above given, does not, in the opinion of the committee, preclude the possibility of its having been a case of superfœtation, yet as twin pregnancies are much more frequent than superfœtations, it would require the very strongest evidence to establish the latter."

(Signed) G. LANE TANEYHILL, M.D.,
A. F. ERICH, M.D.,
B. B. BROWNE, M.D.

DISCUSSION.

Dr. Taneyhill still thought it a case of superfœtation, because when born, although so different in size, they had such a rosy, healthy appearance; also, because menstruation went on regularly from January 19th, 1884, to September 30th, 1884.

Dr. Browne did not think the hemorrhages were menstruations.

Dr. Erich said superfœtation was not proven. We may have menstruation regular when the woman is pregnant; thinks it is strange that if the small fœtus was shriveled up, that it was not expelled until twenty-four hours after the large one.

Dr. Williams thought that if they had both been conceived at the same time we would have two cords attached to the placenta, or some sign of the other cord; it may have been a tubal pregnancy, but does not think so, as the placenta was attached too close to the opening of the tubes; would adopt the superfœtation idea in preference to twin pregnancy.

Dr. Browne said there was no indication of tubal pregnancy; he thought we may account for the difference in size by arrested development.

Dr. Taneyhill said there was no pain or fainting at any time, as we have in tubal pregnancy.

Drs. Williams and *Smith* said they had seen the two fœtuses at time of birth, and they looked fresh and rosy; no signs of malnutrition.

Dr. Smith moved that the report be accepted and the Committee discharged. Carried.

Dr. Jones moved that Dr. Smith be allowed to read his paper on Cocaine, in place of the paper on the appointed subject. Carried.

COCAINE; ITS HISTORY AND USES.

This was the title of a paper read by Dr. J. T. Smith. He said Coca is a member of the red bark family of plants. It is a shrub, and grows to about the height of man; grows best in warm climates, and is found largely in Brazil. The branches are straight, with leaves of a bright green color, thin, and of an oval shape. Good samples of the leaves are uncurled, of a deep green color, with a tea-like odor. The harvest is most abundant in March. When obtained the leaves are spread on woollen cloths, and dried in the sun. The most important constituents of the leaves are a basic, crystallizable substance called cocaine, coca, tannic acid and coca-wax. The effects of the leaves are due to the presence of an alkaloid called cocaine. It is prepared from the fresh leaves as follows: An infusion is first made; this is precipitated by acetate of lead, and the lead is removed by sulphate of sodium. The liquid is then concentrated; carbonate of sodium added; the whole is then well shaken with ether, which is evaporated, leaving the cocaine behind, which is readily dissolved in hydrochloric acid. The salt, as usually seen, is a damp amorphous powder; it now sells at about one dollar per grain. It is now used principally as a local anæsthetic of wonderful power. The abolition of pain in the eye is complete and absolute, and when normal sensation returns, the drug has not left a trace behind.

Dr. Freidenwald said he had used cocaine in ocular troubles and liked it very much; uses a four per cent. solution.

Dr. Erich does not think it will be satisfactory in all cases, as in children it will relieve the pain, but the mental affect will make them struggle.

Dr. J. T. Smith said it left no after affect; this is the most important feature of its use.

The discussion was then closed.

Dr. Taneyhill moved that we celebrate the 19th Anniversary of this Association by a Supper, January 11th, 1885. Carried.

The subject for debate at next meeting will be "Treatment of Irritable Bladder in the Female," opened by Dr. Erich.

On motion, the Association then adjourned.

G. HENRY CHABOT, M.D.,
Secretary.

HOSPITAL SATURDAY AND SUNDAY IN LONDON.—There was an increase of 108 in the number of collecting congregations this year as compared with last. The Prince of Wales, as President of the International Health Exhibition, contributed to the fund $225.00. One congregation gave $53.35. The total sum contributed and distributed to the hospitals was $45,000, an increase of $3,750 over last year.

Editorial.

Physicians and their Female Patients. The London *Lancet* discusses editorially the question of the relations and conduct of physicians to their female patients, and gives some very sound advice upon the subject. The intimate relations of the physician to his patients puts him in a position towards these—and especially towards the female portion of them—which is full of risk, responsibility, and temptation. He is not only their prescriber and medical attendant, but also their intimate friend and often counsellor. Women, especially, are apt to confide in others, and to seek those upon whom they can rely for assistance and consolation. The *Lancet*, therefore, advises that physicians should not encourage or permit intimacy upon the part of their female patients. The older practitioners showed their wisdom by adopting this rule. The length of visits should be carefully regulated to suit the necessities of each case. It is a bad practice to allow what ought to be a strictly professional interview to degenerate into a gossiping visit. Not one moment longer than the clinical needs of the case require should the physician remain in the room or house of his patient. It detracts from his influence and personal authority to chatter familiarly with those whom it is expedient to hold in check. Familiarity with those beneath him degrades and invites ridicule, whilst with his social superiors it amounts to effrontery or insolence which may be tolerated, but will never be liked. The *Lancet* then says that the profession is not wholly guiltless in the matter, and urges caution in professional interviews and a more formally polite manner with infinitely less hand-shaking and fewer compliments. It further suggests the discussion of the subject at the meetings of some influential society, and the formulation of broad principles and rules of conduct for general guidance.

These words of warning and advice from our contemporary we are convinced are not without good grounds and reason. Physicians would be more than mortal were they proof against all the temptations that beset them day by day in their intercourse with patients. It does not do to shut our eyes to the danger or to hush up the apprehensions of conscience and virtue by declaring that acknowledgments upon our part injure us as a profession in the eyes of the public. Do evils exist? Have we not all had evidences repeatedly of the fact? And is it not fair to assume that if one indiscretion reach the day, a hundred are committed in secret? It is no light thing to assume towards the public the relation of physician. Is this appreciated by those entering upon it, or is it sufficiently inculcated upon them? Do we throw around ourselves and those situated like ourselves all those safeguards which are calculated to preserve us from even the shadow of suspicion and reproach in our relations to those who have confidence in our honor and skill? Who can fail to answer no? Who can deny that here is a field for the most beneficial reformation. Our free and easy American life make the profession in this country especially amenable to such dangers as we have pointed out, and the curbs and restraints need, therefore, to be imposed here with far more strictness than among more formal and polite nations.

Extirpation of the Kidney for Renal Calculus.—A most instructive and interesting case of extirpation of the kidney for renal calculus was reported at a meeting of the Royal Medical and Chirurgical Society of London, on Nov. 25th, by Mr. Henry Morris. The successful diagnosis and the successful result of the nephrectomy invest the facts of the case with a peculiar value for the physiologist and for the surgeon. A laborer, aged 35, had suffered from well-marked symptoms of renal calculus of the right side since the end of 1881. In November, 1882, Mr. Morris had explored his kidney digitally and with a probing needle, but did not detect the stone. On October 24th, 1883, the exploration was repeated, but again failing, the kidney was removed through the lumbar incision. The patient made an uninterrupted recovery, and at the present time is at work as a coal-burner, and "is as well as ever he was in his life, and able to work without the slightest inconvenience." The kidney removed was of normal size and appearance, and microscopical examination showed it to be quite healthy. The organ, however, was harder and tougher than usual, and contained a rounded, rough calculus about the size of a marble.

Mr. Morris, after this successful result, came to the conclusion that in nephro-

lithotomy the lumbar incision, and that only, ought to be employed. He endeavored to show that the arguments which have been used in favor of the peritoneal operations are more theoretical than practical, and more likely to lead to pernicious results. This statement drew out a discussion on the relative merits of the lumbar and peritoneal methods of operation, in which Mr. Bryant, Mr. Knowsley Thornton, Sir Spencer Wells, and others, took part, and some instructive facts were adduced in support of each procedure.

Mr. Bryant sided with Mr. Morris, and considered the lumbar operation as the proper one for calculus. The diagnosis of calculus he did not consider any easier when the abdomen was opened. Mr. Thornton and Sir Spencer Wells advocated the abdominal method on the ground that it enabled the surgeon to examine both kidneys and thus make sure a second kidney was present, and in a healthy functional condition.

The operation demonstrated two interesting points: *First*, it showed that one kidney sufficed for the purpose of both, and could do all that was necessary to health. It is quite true, this fact has frequently been demonstrated before upon animals and upon man, but this case gives a more than a usually satisfactory result, and is in the nature of a physiological experiment.

The *second* fact showed the difficulty of diagnosing calculus in the kidney even after this organ has been explored digitally and with the probing needle. This fact should make the surgeon extremely careful in recommending the removal of an organ for a diseased condition which cannot be actually made out before the organ is removed. Mr. Morris was exceedingly fortunate in finding the stone after the removal of the kidney, when he had been unable to detect it before its removal. His success, though extremely brilliant, may be regarded as phenomenal. It may often occur, as in the experience of Mr. Hulke, that well-marked symptoms of renal calculus may be present during life which, after death, were found to be dependent on other causes by the absolute integrity of the kidneys.

The Board of Examiners of Virginia.—We learn from the *Atlantic Medical Monthly* that this body, appointed by the Governor of the State agreeably to the recently passed law regulating the practice of medicine and surgery in Virginia, has met, elected officers and prepared to enter actively upon the discharge of its duties with the beginning of the year. The appointments, so far as announced, seem to be very good, and we hope that the law, which seems to be an excellent one, will be vigorously enforced. The Board will hold semi-annual meetings, in December and April, for examination of applicants for license and transacting other business. Due notice will be given of these meetings. The examinations are to be in writing.

Surgical Scarlet Fever.—*Dr. De Havilland Hall* read a paper recently upon this subject before the Medical Society of London, which naturally elicited considerable discussion and variety of opinion. The immediate motive of the paper was the case of a girl, æt. 6, who had undergone an operation for caries of the lower epiphysis of the left tibia. The day after the temperature rose to 103.5° F., and the entire body was covered with a bright scarlet rash. In the evening the temperature was 104.8° F., but was reduced by cold sponging. The rash lasted four or five days, but the temperature fell almost to normal on the second day. On the ninth day there was desquamation, and on the twentieth day a fine desquamation over the whole body. No albuminuria. The wound progressed favorably. Dr. Hall believed that infection must have taken place before the operation; he also thought that its manifestation was precipitated, if not dependent entirely, upon the disturbance created by the operation. He laid considerable weight upon the tongue as a diagnostic factor in such cases, and urged isolation, even when there was a doubt as to the nature of the case.

In the discussion following doubt was expressed as to the correctness of the diagnosis, and even granting this, whether the occurrence was not a mere coincidence. Attention was called to the occurrence of various forms of rash in association with abscesses in various situations, after extraction of teeth, after confinement, etc.

In reply to these objections, the frequency of these cases was urged as negativing the idea of coincidence, and several practical surgeons of experience declared their belief

in the reality of the scarlet fever. The latter view seems to us to be the correct one if it be true, as stated, that the disease is capable of being propagated by means of this traumatic exanthem. The course of the two affections is similar, although variations occur in the traumatic form as well as in the idiopathic. The correct view is probably that the wound is only a predisposing cause of the disease, rendering the patient particularly liable to acquire it on even the slighest degree of exposure. With our prevailing views as to the germ origin of such infectious diseases, this is as far as we can go, and it corresponds with the opinion of that eminent pathologist and surgeon, Sir James Paget.

Miscellany.

Antipyrin.—Dr. Huchard terminates a lecture on the Therapeutics of the new antipyretic, Antipyrin, which he delivered at the Hôpital Bichat (*Union Médicale*, November 29 and December 6), with these conclusions:—(1) Antipyrin constitutes a powerful and certain means of lowering the temperature in almost all febrile diseases, as typhoid fever, pulmonary phthisis, pneumonia, pleurisy, acute articular rheumatism and cerebral rheumatism, angiocholitis, erysipelas, diphtheria, puerperal fever, scarlatina, phlegmon, abscess, &c. It mitigates the symptoms which are due to the pyrexia, acceleration of the pulse and respiration, dryness of the mouth, &c., but it does not seem to possess any *direct* action on the respiration and circulation. (2) It is an antipyretic, but not an antiperiodic, whence its inefficacy in intermittent fevers as a *preventive* of the paroxysms. (3) Its administration only gives rise to slight and occasional complications, such as moderate sweating, pharyngeal constriction, slight nausea or vomiting, and in some relatively rare cases to a rubeoliform or scarlatiniform eruption. No tendency to collapse is produced, nor any intoxication such as is caused by preparations of cinchona and salicylic acid. (4) Numerous observations have demonstrated that it constitutes a powerful, and up to the present time the sole, means of efficaciously lowering the temperature in tuberculous subjects. After a dose of two grammes, administered especially in the evening at the time of the recurrence of fever, the temperature falls half a degree centigrade, by the end of half an hour and sometimes after a quarter of an hour. It then diminishes progressively, until the normal temperature is attained in an hour-and-a-half or two hours. It is, however, sometimes necessary to prescribe an hour or two later another dose of one or two grammes; but in phthisical subjects it, in consequence of the very certainty of its actions, and with the aim of avoiding accidents that may be induced by hypothermia, should only be administered in small and increasing doses, as from two to four grains. (5) The antithermic effect is ordinarily maintained in these patients for from six to nine hours, and is sometimes perceptible on the following day, during which the temperature does not regain its previous height. The subsequent rise of temperature takes place progressively, resembling in that the course of the defervescence. It is never sudden, as with kairin, and is never accompanied, like the latter substance, with more or less prolonged shivering. (6) It is eliminated in the urine, in which its presence is recognized two to four hours after its administration during a period of from 30 to 48 hours. Some drops of perchloride of iron poured into urine of patients taking this medicine immediately produces a highly characteristic red color. (7) Dr. Huchard cannot speak from his own experience as to its effects in typhoid fever; but he is disposed to regard the doses of from six to eight grammes per diem, recommended by various observers, as excessive, as in several of the cases in which they had been employed a condition of hypothermia has been induced, the temperature falling to 35° or 36° C. In typhoid fever, also, the temperature, after having been lowered, will about the fifth or sixth day rise again a degree centigrade for about an hour, after which time it resumes its regularly descending progress. Dr. Huchard has also noted the same temporary ascent of the temperature during the apyrexia, due to action of antipyrin on the fever of phthisis.—*Lond. Med. Times.*

Transmission of Phthisis.—At the late meeting of the Hygienic Congress at the Hague, two important communications were read on this subject. In the first of these,

Prof. Corradi, of Pavia, draws the following conclusions:—1. That the contagion of pulmonary phthisis is possible. 2. Prolonged cohabitation is one of the principal conditions of its occurrence. 3. Debility and all causes which diminish the power of organic resistance render it more easy. 4. The possibility of transmission through the medium of clothing, goods, &c., has not been sufficiently proven. 5. It is also doubtful whether the milk or flesh of tuberculous animals can give rise to the transmission, especially after culinary preparation. 6. That, at present, regulation of cohabitation is the only prophylactic measure that can be had recourse to. 7. Investigations should be continued in different countries, with the aid of a uniform formula. The other paper was a report from M. Vallin, on the "Danger of alimentation by means of the flesh and milk of tuberculous animals," of which these are the conclusions:—1. The tuberculosis of animals is specifically identical with human tuberculosis. 2. It has been proven that the ingestion of raw tuberculous matters may engender tuberculosis. 3. The injection under the skin, or into the peritonæum, of the blood or muscular juices of phthisical animals, is capable of determining phthisis. 4. The ingestion of the raw flesh of phthisical animals is capable in certain cases, of transmitting the disease, and especially abdominal tuberculosis. 5. The inoculability of tubercle is not destroyed, except by a notably higher temperature than that attained by the central portions of roasted meats. 6. The milk of phthisical cows may transmit tuberculosis, and is especially dangerous when the mammary glands are tuberculous. 7. Boiled tuberculous milk is harmless. 8. In order to guard against all danger, we should, at all events provisionally, prohibit the use of meat of animals the subjects of confirmed generalised tuberculosis, with commencing emaciation. 9. The habit of eating underdone meats should be discouraged, and as a matter of security, milk should always be boiled. 10. Attempts should be made to diminish the frequency of tuberculosis in animals by choice in breeding, improved stalling, isolation of infected animals, disinfection of contaminated stalls, &c. 11. Tuberculosis of horned cattle should be ranged among contagious diseases affecting them, and submitted to the laws applicable to these. 12. Assurance societies against tuberculous cattle should be encouraged, in order to indemnify the proprietors for losses from this cause.—*Progrès Medical*, September 13.

Cremation and Burial.—If, says Dr. Finlay, of Brooklyn, in a recent address on this subject, one desires to know the relative merits of the two practices, he cannot do better than to compare the sanitary conditions in this respect of the Chinese and Japanese; or, in India, the condition of Buddhists and Brahmins, who practice the cremation of the dead, with that of the Musselman population, who practice earth-burial. China, in the region of its cities, for miles around is a vast, hideous and pestilential burial-ground; while Japan, in the vicinity of its centres of population, is a land of gardens, wherein grow fruits and flowers, and all that the vegetable kingdom can minister to the comfort and happiness of man. The contrast would be yet more marked if the entire population of Japan practiced cremation, instead of only a part of it, and especially were that practice in accordance with approved modern methods, instead of being in great part by the open pyre. Much as religious prejudices have to do with determining the methods of disposing of the dead, there is yet no really essential relation between cremation and religion; and as enlightened views are obtained, people everywhere are learning more and more that the disposal of their dead is a purely sanitary, economical and æsthetic question; and that religion has to do only with the life that is and with the immortal part of man in the life to come. More and more also are we learning that whether in the grave or in the crematory fire, and whether in an hour or in a hundred years the body must be dissolved into its constituent elements; that this process is simply one of oxidation, or burning, as more familiarly known to us. In the grave it is "cremacausis," as the distinguished Liebig designated it: A slow burning amid festering putrescence. In the rosy glow of the crematorium it is rapid burning in cleanliness and light—but burning in either case. While, however, the conditions and the process cannot affect, as to the body itself, the ultimate result, as to the effects upon surviving friends and neighbors of the deceased, and upon the sanitary conditions of the region round about, the

differences, are just the difference between health and disease—the difference between life and death.—*Brit. Med. Journal*, December 6th.

Administration of Anæsthetics.—*Mr. Woodhouse Braine*, F.R.C.S., Lecturer on Anæsthetics to Charing Cross Hospital, says on this subject, among other things, the best plan is to commence with nitrous oxide and continue the effect with ether; the latter is best for all short operations. Every known anæsthetic will prove fatal at times. The following agents produce death through the circulation as well as the respiration: chloroform, bichloride of methylene, bichloride of ethidene, bromide of ethyl, ethylic methylic ether, and many others of the chlorine series. Nitrous oxide and ether prove fatal only by causing cessation of the respiration. Chloroform death in the very great majority is sudden, beginning at the heart; when this once entirely ceases death is inevitable, whereas recovery may still be looked for when respiration alone ceases. Nitrous oxide is the quickest and safest, but at the same time most difficult anæsthetic to administer with effect; it must be given pure and air rigidly excluded. Pregnant women take it well, and great age is no bar. The best time for administering anæsthetics is early in the morning, less being required then, and the stomach being then naturally empty, and the nervous system of the patient is also at its best. The lungs and heart should always be examined, if for no other reason in order to reassure the patient and dissipate his anxiety. Artificial teeth should always be removed. The most comfortable position for the patient is on the side, with one hand and forearm under the pillow, shoulders slightly raised, neck a little bent to allow the saliva to run out of the corner of the mouth. Faintness after operation requires a lowering of the head, which is easiest effected by raising the lower end of the bed. When required artificial respiration should be begun without a moment's delay. Should much pallor be present, or syncope appear imminent, nitrate of amyl affords the quickest means of restoring the heart's action; the glass capsules are the most convenient form for use. The anæsthetist's bag should always contain a pair of tongue-forceps, a Fergusson's gag, a scalpel, forceps, tracheotomy tube and a few nitrite capsules. After operation the patient should have no food for three hours. To sum up, we shall do well to avoid all anæsthetics in combination or by themselves which tend to depress the heart's action; for all short operations nitrous oxide is best; for longer, except where it is advisable to avoid any hemorrhage, as in some eye-operations, and when the cautery is used, ether can be made to fulfill all requirements; the best time for operating is the early morning. the nasal tubes are of little use; nitrite of amyl is the best cardiac stimulant.

Anteflexion of the Uterus and its Associated Pathological Conditions; their Prevention and Treatment.—In a paper on this subject (*Amer. Jour. of Obstetrics*, Sept. and Dec., 1884), Dr. W. Gill Wylie of New York, sums up the following conclusions:

1. There is undoubtedly a certain number of cases in which a marked degree of anterior curvature gives no painful symptoms.

2. Anterior displacements are the result, rather than the cause of the pathological changes in the uterus. They may add to and sometimes intensify disease, but are rarely, if ever, the primary cause.

3. Dysmenorrhœa with anteflexion is rarely, if ever, chiefly and directly due to the flexion, but the latter in some cases may aggravate the pathological conditions which are the real cause of the pain.

4. The attempt to correct anterior displacements by the use of pessaries is rarely, if ever, sufficient to effect a cure, unless the cervix is dilated at the time, or other pathological conditions are treated. The use of mechanical supports may give some relief, but they are merely palliative, and as used by many they frequently do harm.

5. The true morbid condition of the uterus in most cases of anteflexion is one of imperfect development, while the uterine canal is more or less stenosed by the degenerate and contracted state of the uterine tissues, and the mucous lining is degenerated and atrophied, often hyperæsthetic, especially in that part of the organ where its circular fibres are most powerful and contracted, at the os internum.

6. If the above is true, the treatment obviously would be to stimulate development by improving the general health, and by the local use of electricity, to relieve the

stenosis by dilatation or division and divulsion, to perfect the drainage, and bring about a healthy condition of the mucous lining.

Treves on Treatment of Intussusception.—For acute and subacute cases only, opium first, as it gives rest to the intestines, relieves pain, and diminishes shock. Nothnagel produced all the various forms of intussusception in animals by means of electrodes. Opium gives better effect to the subsequent treatment. Feeding is of no moment in acute cases; thirst may be relieved by enemata. Enemata, with a view to reduction, should be adopted as soon as the patient is under the influence of opium. In really acute cases they do no good after the second day. Chloroform should be administered in children. The best positions are the knee and head or knee and elbow; sometimes the lateral abdominal. Inversion is of no use. A tumor can be felt either through the parietes or per rectum in nearly fifty per cent. of the cases, and the effect of enemata on the tumor should be watched. Massage, electricity, carbonic acid, enemata, and metallic mercury are useless and waste time. Laparotomy should be resorted to without delay, and should be a first, not a last, resort. The mortality of the operation is high, but would probably be much less if performed earlier and when patients are less exhausted. In really acute cases operation should be performed within forty-eight hours, and in infants, if possible, within twenty-four hours, the median incision being recommended in all cases. The general mortality was 72 per cent. in 33 recorded cases; when reduction was easy, it was 30 per cent., and when difficult, 91 per cent. Resection should be done if the intussusception be irreducible or gangrene has set in.—*Lancet*, Dec. 13.

Sir Andrew Clark on Alcohol.—This high authority recently delivered a lecture before the Young Men's Christian Association, at Exeter Hall, London, (*Brit. Med. Jour.*) in which he said in substance: The perfectly healthy man is better without alcohol, which is not a helper but a hinderer of work to such an one. Though sure of this it has never been proven that a small quantity of an alcoholic liquor taken say twice daily with meals is injurious. If some of the abstaining brethren in their zeal for the propagation of their favorite theory, would only bear in mind this fact, the progress of total abstinence principles in the profession would advance at a rate hitherto unknown. There is a physiological quantity needed to produce certain appreciable effects in the living body, and of the harm or benefit of any dose under this physiological quantity we have had as yet no reliable evidence. It is possible that this quantity may by future observation be found to have been put at a higher amount than more extended observation will warrant. Agreeing in the recognition of this fact there is ample scope beyond the physiological quantity for argument pro and con on the subject of nephalism, in the general tendency of intoxicating beverages to narcotise, derange and disturb. Discussion would thus be conducted in consonance with sound physiology and common sense.

Excision of Tumor of Brain.—We understand that the case of excision of a tumor from the brain, a brief record of which appeared in our last issue, is, according to the latest accounts, progressing favorably. The case, which is believed to be the first of the kind that has been thus treated in this or in any other country, is looked upon with much interest in medical circles. The chief symptoms which led Dr. Hughes Bennett to diagnose the extent and locality of the tumor were paroxysmal twitchings of the left side of the face, alternating with twitchings of the arm on the same side, followed by slowly progressive paralysis of the hand and later on by twitchings of the eyelids and leg without paralysis. These symptoms were accompanied by double optic neuritis and violent headache. The conclusion arrived at was that there was a tumor, probably not larger than a walnut, situated at the upper third of the fissure of Rolando. The skull was trephined by Mr. Godlee over the corresponding spot under which the convolutions appeared to be healthy. An incision was then made in the ascending frontal convolution, and a quarter of an inch below the surface a tumor of the size suspected was discovered and removed. The operation was performed under strict antiseptic precautions.—*Med. Times and Gazette.*

Treatment of Hæmorrhoids by Forced Digital Dilatation.—In relation to Pro-

fessor Verneuil's paper on this subject (*Medical Times*, July 19, p. 93), M. Charles Monod, *agrégé professeur*, writing to the *Gazette des Hopitaux*, in warm approval of the views expressed in that paper, observes that treatment by dilatation has now become the habitual practice of the younger surgeons. But he adds that he does not think that we should accept a qualification of the practice that is always observed, and is advocated by Professor Verneuil himself; and that is, in case of gangrene having occurred or being about to take place, the application of dilatation should be deferred, as after the slough has come away the relief of the strangulation of the hæmorrhoids which produced it will occur. The suffering of the patient is of too dreadful a character and a radical cure of such immediate importance, that M. Monod advises that, in spite of this complication, the dilatation should at once be proceeded with; and he relates an important case in which this condition existed in a very aggravated form, producing the most horrible suffering, that no anodynes relieved, and which was instantly remedied by dilatation, the disease being also completely cured at the same time.—*Med. Times and Gazette.*

Pasteur's Pets.—While M. Pasteur is absent in Brazil investigating yellow fever, he will, the *Union Médicale* observes, be spared the maledictions of the inhabitants of Villeneuf-l'Etange and other localities near Paris, for having turned out among them, as they allege, numbers of mad dogs. Of course, these are in reality dogs which have been rendered proof against rabies by inoculation with attenuated rabies virus. Moreover, these dogs are not turned loose, harmless as they are supposed to have been rendered, but are under effectual surveillance. However this may be, several communes, in place of associating themselves with M. Pasteur's discoveries and offering facilities for their pursuit, regard the arrival of the dogs as a calamity, and are opposing their installation as violently as they would the establishment of an industry prejudicial to the public health.—*Med. Times and Gazette.*

Scarlet Fever in Pregnancy.—Dr. Leale terminates a paper on this subject with the following conclusions: 1. Scarlet fever may attack the fœtus in utero. 2. A large proportion of children born with scarlet fever recover. 3. Scarlet fever of the new-born child has the same manifestation as in later life. 4. It may attack the woman in pregnancy and also immediately after child-birth. 5. It is exceedingly fatal during pregnancy and parturition. 6. It rarely if ever attacks the parturient woman if she has had it previously. 7. It causes death by coma, exhaustion, or convulsions. 8. Being a self-limited disease, it is best treated by relieving dangerous symptoms, and in accordance with the rules of hygiene. 9. It only exceptionally occurs during the ages that women bear children, therefore the proportion of those liable to contract the disease during pregnancy and child-birth must necessarily be small. 10. Scarlet fever and septicæmia are distinct diseases, being unlike in many respects.—*Med. News.*

A French Treatment for Ulcer of the Leg.—Dr. Vidal recommends (*L'Union Médicale*, Oct. 12, 1884) the following treatment, which he has found very efficacious, especially for indolent ulcers with pale base and ichorous secretion: First, wash the ulcer with an infusion of oak-leaves, then cover with a layer of subcarbonate of iron. A poultice of potato starch is then applied and retained by a roller bandage. Healing is complete in ten to forty days. The subcarbonate of iron has an action upon the ulcer at the same time astringent and tonic. It gives new life and activity to the tissues. The galvanometer shows a considerable giving off of electricity, which explains, according to the author, the beneficial action of the iron.—*Med. Record.*

A Demonstrating Vaginal Speculum.—Dr. H. Macnaughton Jones gives in the last number of the *Lancet* an illustration of a speculum which he has invented which will enable the gynecologist to demonstrate to students the condition of the intra-vaginal parts, without exposing the patient. A ring with a groove receives the mouth of a speculum—any large-sized speculum. The ring is clamped by means of a screw. Attached to the ring is a nickel-plated steel bracket with three joints, having at its distal extremity a mirror working in a universal joint which renders it capable of being placed at any angle or plane to the orifice

of the speculum, from which it is 25 c. m. distant. A magnificent image can be gotten by attaching a slightly concave mirror.

Prophylaxis of Migraine.—Dr. Haig remorts in *The Practitioner* the case of a young man, thirty years of age, who suffered torments from frequent attacks of hemicrania, which ceased entirely after he adopted a purely vegetable diet, although they had recurred as frequently as three times a week before that time. Dr. Haig thought that possibly the neuralgia was caused by poisoning with ptomaines formed in the intestinal canal during the digestion of meat. After living upon an exclusively vegetable diet for a considerable time he was able gradually to return to a bill of fare containing a small quantity of meat. —*Med. Record.*

Terpine. — Under this name M. Lépine gave an account at the Lyons Société des Sciences Médicales (*Lyon Médical*, November 16th), of a new therapeutical agent produced by a chemical combination of turpentine, alcohol, and nitric acid. In doses of from 29 to 40 centigrammes he has found it very useful in chronic, and even in sub-acute, bronchitis, greatly facilitating expectoration. Advantage has also been derived from it, in the same or similar doses, in some cases of chronic nephritis. It is a diuretic acting directly on the renal epithelium, requiring to be used with circumspection.—*London Med. Times.*

Chronological History of the Discovery of Disease Germs.—*Dr. Andrew Smart*, of Edinburg, gives the following (*Brit. Med. Jour.*) as the chronological order of discovery of disease-germs:

I. Rinderpest-germ, Dr. Smart, September, 1865; 2. Relapsing fever germ, Obermeier, 1868; 3. Anthrax germ, Koch, about 1874; 4. Vaccine germs (probably analogous to small-pox germs not yet discovered), Sanderson & Chanveau, 1869; 5. *Filaria Sanguinis Horminis*, Manson, 1881; 6. Typhoid fever germ, Ebert, 1880; 7. *Bacillus tuberculosis*, Koch, recently; and 8. Cholera germ, Koch, recently.

Benzoin in Chaps and Frost-bites.—Dr. Carl Seiler, of Philadelphia, has called attention to the value of tincture of benzoin in the treatment of chapped hands and frost-bitten feet. He has used it in a number of cases with great success, simply painting the skin with it. The stocking may be prevented from sticking by rubbing oil over the benzoin.

Veratrine in the Treatment of Deafness of Labyrinthine Origin.—The following formula, suggested by Gruber, is published in the *Union Médicale:*

Veratrine.....	0·10	gramme;
Iodine.....	0·025	"
Iodide of Potassium...	1·00	"
Simple cerate.....	10·00	grammes.

Hospital Saturday and Sunday in Manchester.—In Manchester, England, where the movement originated, the collections of the Hospital Saturday and Sunday Association amount this year to over $42,000, viz.: Sunday collection, $27,500; Saturday collection, $14,700. During the fifteen years that the movement has been in existence there $534,000 have been raised.

Medical Items.

The five Dublin medical schools have now 790 students.

Nephrectomy has been performed in Italy ten times, with six recoveries.

Professors von Wittich, of Königsberg, K. von Vierordt, of Tübingen, and Kolbe, of Leipzic, are dead.

Dr. Geo. Harman, æt. 63, died in Cambridge, Md., Dec. 21st. He had been an invalid several years.

The Hospital Saturday and Sunday Collections for 1884 were taken up in Baltimore, on December 27th and 28th.

Dr. Geo. W. Gay, of Boston, has operated for pseudo-membranous laryngitis sixty-two times with success in twenty cases.

Murrell is using a four per cent. solution of cocaine in chloroform for supraorbital neuralgia with the most satisfactory results.

By the recent charity bazaar held at the Natatorium, in Baltimore, for the Nursery and Child's Hospital, $6,500, net, were realized. This will be utilized in furnishing the new wing of the hospital.

There are 415 patients now in the Maryland Hospital for the Insane, the building being constructed to accommodate only 325.

Dr. T. S. Bell, one of the oldest and best known physicians of Louisville, was found dead in bed on Saturday last; it is supposed from heart disease.

The differences in the Baltimore Medical College have been settled, the Byrd faction withdrawing from the contest and obtaining an incorporation under a new name—"Baltimore University."

The friends of the late Dr. Mahomed have opened a subscription for his widow and children, and at a meeting held Dec. 10th, $3,000 were subscribed and a committee appointed to invite further subscriptions.

According to the Commissioner of Education, General Eaton, there were 8,681 medical students in this country in 1873 and 15,151 in 1882. The medical schools increased during the same period from 94 to 134.

There were 22,125 deaths in India in 1882 from poisonous snakes and wild animals—tigers, leopards, wolves, bears, etc. Notwithstanding the increased efforts to prevent them, the number of deaths has actually increased of late years.

The Board of Trustees of Columbian University, Washington, D. C., on the unanimous recommendation of the medical faculty have decided to admit women to the study of medicine in that institution, with all the privileges heretofore accorded only to males.

It is announced that Drs. Klein and Gibbs, of the English Cholera Commission, have presented a report which is altogether subversive of Koch's theory, the common bacillus not being found in all cases of cholera and never in the blood or tissues, and inoculations on the lower animals having failed.

It is announced that the last link in the chain of evidence with reference to the causative relationship of the common bacillus to cholera has been supplied, Nicuti and Rietsch, of Marseilles, and also later, Koch himself having transmitted the disease by introducing cultures of the bacillus into the rectum.

A meeting of the Trustees and lady visitors of the Baltimore Eye, Ear and Throat Charity Hospital was held a few days ago, at which a resolution looking to the purchase of a permanent site for the hospital and the raising of an endowment fund was adopted, and a committee appointed to take charge of the work.

Dr. Atthill, of Dublin, uses the following lotion in pruritus vulvæ, and it is also applicable to pruritus ani, a pledget of cotton being soaked in it and passed up the anus and left there till the next defecation when it is to be removed: Acid carbolic, gr. 20; tinct. opiii., ℥ ss.; acid hydrocyanic dilut., ʒ ij.; glycerine, ℥ ss.; aquam ad., ℥ iv.

With a view to securing the greatest possible security against cholera, two disinfectant stations will be created in Berlin; each station is to have a disinfecting machine and four more of the latter will be kept in reserve. Twice a week all the rooms, coridors and kitchens in all Berlin barracks are now washed with a solution of carbolic acid, and the same is sprinkled in all spittoons.

No person can keep a drug store in Baltimore without first passing an examination by three commissioners of pharmacy and practical chemistry, appointed by the Governor, unless he holds a diploma from a regularly chartered and recognized college or school of phamacy, based upon a full apprenticeship of four years as a pharmacist, in which case it is sufficient for him to present satisfactory evidence of such facts to the commissioners. The examination is directed chiefly to ascertaining the practical knowledge of drugs and ability to compound prescriptions.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from Dec. 23, 1884, to Dec. 29, 1884.

McParlin, Thos. A., Lieut.-Colonel and Assistant Medical Purveyor, granted leave of absence for three months, on surgeon's certificate of disability.

Johnson, Henry, Captain and Medical Storekeeper, directed, in addition to his present duties, to perform the duties of Assistant Purveyor in New York city.

Wales, P. G., First Lieutenant and Assistant Surgeon, relieved from duty in Department of Colorado and ordered to Department of Arizona.

Original Article.

INVERSE TYPE OF TEMPERATURE IN TYPHOID FEVER, WITH A REPORT OF TWO CASES--TEMPERATURE PECULIARITIES IN EPIDEMICS, WITH A REPORT OF SEVEN CASES IN ONE FAMILY.

BY W. C. HOLLOPETER, M.D., OF PHILADELPHIA.

The classical investigations of Wunderlich, Thierfielder and Traube have done much to simplify the study of fever, and by their deductions they have rendered it possible for us to differentiate typhoid from all the other continued fevers by its temperature alone. This universal tendency to refer a given symptom to an established, or partially established law, has done much to lessen the interest of individual work; for those cases marking the exception are, as a rule, looked upon as complications, and slight causes are frequently brought forward to explain the apparent departure from the established rule. Dr. J. C. Wilson, in his admirably written work on "The Continued Fevers," tell us that "marked deviations from the typical course of the temperature are always due to special causes. These causes, in many cases, cannot be discovered by the most searching investigation. On the other hand, upon inquiry, clinical facts of importance are often discovered, and it is therefore the duty of the physician, in every case when marked deviations occur, to make diligent search for their cause."

I enunciate a well-recognized fact when I state that every physician in general practice has had cases of typhoid fever where the temperature record has been irregular, when, at the morning or the evening visits, the thermometer has registered the same, or has shown some unusual features in the evening exacerabation, or morning remission, departing in some unsatisfactory manner from the gracefully arched curve of Wunderlich.

It has frequently been my lot to treat cases of fever having every symptom of typhoid, yet not responding to the well-marked type of temperature, as described by Wunderlich. For a long time, it was very difficult to assign any cause for the variation, although it is natural for complications to disturb the rule, especially when we anticipate a typical curve in the temperature chart.

Dr. Wm. Pepper has stated, in a recent clinical lecture, that "it was the exception, and not the rule, to find a typical case of typhoid fever." Although every symptom may be uncertain, or even frequently wanting, in some cases of typhoid fever, yet I believe the temperature, the peculiar form especially, remains the most constant factor, and, as Griesinger states, it "generally controls the situation."

During the last seven months, I have had under my care a case of typhoid fever in which the temperature record corresponded to the "inverse type," as described by Traube.

Baumler, in drawing attention to this unusual character of the temperature, states that, in the great majority of the cases, the daily fluctuations follow the rule of health, the exacerbation taking place in the evening; we sometimes meet with cases where this order is reversed, the rise taking place in the morning, and the remission occurring in the evening.

This "inverse type," so named by Traube, of the daily fluctuations of a febrile temperature has been observed in some rare instances in typhoid fever.

I have been unable to find any additional reference to this usual type of temperature in the systematic treatises on fever; Liebermeister or Murchison do not mention it in their works, nor have I been able to find any clinical reports bearing on the subject, in any of the medical journals.

The clinical notes of my case are as follows:

Frank M., aged 14, of thoroughly healthy parents, was taken ill May 15, 1884. My friend, Dr. Schoales, being the family physician, was sent for. The doctor was indisposed at the time, and I was requested to take charge of the patient. I found that the boy had been sick for two days, a slight chill occurring three days previous, and ever since he had been feverish, restless, and stupid; he had refused food and complained of headache; he had also slight nose-bleed and loose bowels. The history of the case was not unusual, having every

* Read before the Philadelphia County Medical Society, November 26, 1884.

well-marked typhoid symptom, and was of interest in the character of the temperature alone, which was as follows:

	A. M.	P. M.	Pulse.
May 15,	102⅘°	102°	100
" 16,	104	103⅗	108
" 17,	103½	103	108
" 18,	103⅘	102⅗	112
" 19,	105⅖	104	116
" 20,	104⅗	101⅖	96
" 21,	103⅗	102⅘	108
" 22,	100	102⅕	96
" 23,	99⅘	99	96
" 24,	100⅘	100	96
" 25,	101⅖	101	96
" 26,	101⅘	101	100
" 27,	98⅘	99⅕	100
" 28,	100	99⅗	100
" 29,	100⅕	99	100
" 30,	101⅗	99	98
" 31,	101	97⅗	98
June 1,	100⅕	99	100
" 2,	98	98⅗	98
" 3,	98⅗	97⅗	98

In this case the boy had been complaining for a few days, according to the statement of the parents, before advice was called in. How much longer he had been ill we are unable to state, judging from the elevation of the first temperature (102⅘°), the case was evidently well on in the first week.

The exacerbation recurring so regularly in the morning, and the remission taking place as faithfully in the evening, caused me to watch the case with unusual vigilance. We could hardly be mistaken in the character of the fever—Dr. Schoales subsequently visiting the case with me frequently and corroborating the diagnosis; the stupid and listless countenance, the distended and tympanitic abdomen; the rose-colored spots, few, but constant throughout the illness; the gurgling in the lower portion of the abdomen; the loose bowels; the nose-bleed; the deafness, all conjoined to render the diagnosis certain. Then the duration of the illness, while not very severe, extended over four weeks, which corresponds to the average duration of uncomplicated typhoid fever.

The treatment of the case was such as to have but little effect on the temperature, except to lower it; diet exclusively of milk and milk food; the recumbent position faithfully maintained; large and well ventilated room, thoroughly disinfected. No drug was used likely to influence the fever, with the exception that, during the prevalence of the highest records, thirty grains of quiniæ sulphatis were exhibited in ten-grain doses, two hours apart, during the night. This was ordered on three successive evening visits. Cold-water sponging of the body was continued frequently as long as the temperature remained above 102°. We were unable to discover any complications whatever, in fact there were none; no bronchial irritation, no disturbance of the alimentary tract. The course of the fever was so uniformly regular, the various symptoms occurring in their usual order, and the whole phenomena of the fever convincing as to its character, except the very important factor noticed in the *inverse type* of temperature.

The want of uniformity in the temperature record of the case just noticed, recalls the facts in a patient I had under my care nearly three years ago. The clinical notes recorded on the back of my temperature sheet at the time, are briefly as follows:

Walter, æt. 7, was a well-developed boy, and the youngest in an exceedingly healthy family. The mother informed me that the boy had commenced to manifest a disinclination for food and play five days before any trouble was suspected. I was therefore called in on the evening of the fifth day. I found the little fellow quite delirious, with a temperature of 103⅖°, a full pulse of 130, respirations 26, face flushed, and apparently swollen, eyes congested, skin dry and hot, bowels confined. Ordered a fever mixture.

In the morning, temperature had fallen to 100⅕°, pulse 100. The patient had relapsed into a quiet sleep during the early morning hours. The skin had become moist. On a more careful examination I found the abdomen tender, somewhat tympanitic and distended. The mother stated that there had been during the past ten days occasionally slight nose-bleed. The bowels showed a disposition to be free, yet, while not constipated, they had not been open regularly every day, now one or more free movements occurred daily. The third day, end probably of first week, if not more, the temperature, with a single exception, did not go above 102°, but had a gradual decline. The interesting feature was the morning record, which was higher than the

evening. The unusual feature continued for twelve days, the amount of variation was from one to one and a half degrees.

On the twelfth day, about the twentieth of the attack, the morning temperature reached 103°, without any other unusual symptoms, after which it changed and ran as a typical case of typhoid fever in convalescence; morning 100°, evening 102; morning 98⅘°, evening 101⅘°, etc.

The downward curve was thus continuing uninterruptedly until the seventeenth day, when the temperture ran up to 102° again; following this rise, the morning record marked 98°, and an intestinal hemorrhage of over four ounces of dark blood, following an unusually large fæcal movement.

The thermometer never registered a temperature after this above 100°. The case made a good recovery, convalescence slow. In this case we had a temperature curve closely following an ordinary typhoid-fever chart, with the unusual exception of the twelve days of *inverse type*, with no discoverable complications to explain the cause.

I have not deemed it expedient to enter into an accurate analysis of each any every symptom of the foregoing irregular cases, knowing it to be exceedingly burdensome, yet I hope that I have sufficiently outlined the general features of typhoid, the phenomena of which are so constant as to make a diagnosis practically certain.

I wish now to present the salient points in a group of seven cases, occurring in the form of an epidemic in one family, in which the victims followed each other to bed in rapid succession, four of whom suffered very severe and prolonged relapses. All, however, eventually made a good recovery. It is not my intention to narrate these cases as especially unique or exceptional, but as taking place under one roof, and springing from one well-recognized cause; the variation in the temperature record alone became an interesting element of study.

The fever occurred in a very healthy German family; the parents, as well as the children, were free from any predisposing weakness.

Case I.—Mary, æt. 13, was the first to take sick. I made my first visit to her December 6, when I obtained the following history: The patient had been complaining for nearly a week, of weariness, chilliness, aching in limbs, back and head, loss of appetite, and a general disinclination to any physical exertion. I found her, at 12 M., with a temperature of 104⅘°, pulse 112, skin hot and dry, puffiness around the eyes, with an injected conjunctiva, face dark and flushed. During the day had diarrhœa, with vomiting. At 8 P. M., of same day, vomiting (continuing) of thick tenacious mucus, tinged with blood and bile; bowels were opened seven times during the afternoon. Since my morning visit, the girl has had low muttering delirium, but can be aroused by speaking in a loud voice. The back-ache was so very severe as to merit especial attention, it being more pronounced than is usually found in bad cases of typhoid. The girl constantly complained of it during the first ten days. On the same evening, at 9 P. M., the thermometer had registered 105⅘. In the morning it was 104⅘°; in the evening it was 105°. During the day and night, vomiting and purging continued nearly hourly—fifteen times, by the nurse's report.

At the end of the eighth day, the second day of my visiting, the back-ache continued violently, the hands being involuntarily placed in that region. Bowels continued loose, vomiting the same. Distention and tenderness of the abdomen decidedly marked, with gurgling in right iliac fossa, tongue heavily coated, dark and foul, sordes on teeth and lips. Vomiting discontinued on third day after taking her bed. Temperature 104⅘° in morning, 105° in the evening; low muttering delirium, alternating with violent outbursts; three or four well-defined, rose-colored spots, at this date made their appearance on the abdomen. After the fourth day, probably the tenth or twelfth day of her sickness, the temperature did not run higher than 104⅗°, but did not fall below 102° until the eighteenth day. One very noticeable feature in this severe case was that, for two weeks, every other morning's fall was less or intermittent in character, while the evening exacerbation remained the same. During this period, there existed the wildest delirium, it being difficult at times to retain her in bed; bowels frequently moved involuntarily. The girl gained her strength very slowly; it was five weeks before the temperature approached normal, and it was ten weeks before she was able to leave her bed. She, however, made a good recovery.

The point worthy of attention is, that

the temperature in this nearly fatal case remained nearly the same for the morning and the evening record. Immermann tells us, that only in cases in which the fever is very severe, and the absolute temperature very high, that the difference is less, and does not exceed three-fourths of a degree.

Case II.—The second member of the family to fall ill was the mother, æt. 32, who had acted as constant nurse to the daughter. It was thirty-four days after the daughter was taken sick, and the daughter was yet in bed, that the mother was compelled to relinquish her duties. I might state that the mother was on the eve of her confinement, that she watched and waited on her sick child up to the hour of her illness, she passed safely through her labor, remained in bed one week, was up and around the house for *five days* before she had any decided symptoms of fever. She had a slight chill which was soon followed by a temperature of 104⅗° in the evening. This was, however, the highest point reached. She had no delirium, nor vomiting. Bowels were opened daily, but not unnatural. The temperature remained high for over a week, ranging between 103° and and 104½°. It had a gradual decline for over thirty-six days, when it reached normal, without any unusual variations between the morning and evening record. Convalescence was very slow. The record was a typical temperature record from the second week of typhoid, yet much milder than the child. The puerperal state did not seem to modify the course of the fever or endanger the life of the patient.

Case III.—The husband and father, æt. 36, a house carpenter by trade, rugged and compactly built German, was next on the list. He was a perfect type of physical perfection. He continued his work up to the hour of taking his bed, February 10th. He had complained of a cold, headache, and sore throat for two days previously. I found him, on the morning of the tenth, with a temperature of 105⅗°, pulse 90, respirations 20; dry, hot skin, dark and infected countenance; bowels loose, abdomen flat; very stupid and sleepy. In this case the pulse was full and regular, never going above 90, yet for over two weeks his temperature lingered around 105°, with profound stupor, alternating in the wildest delirium. He had during the second week, constant *subsultus tendinum* and frequent involuntary movement of the bowels. On the twenty-second day of his illness he suffered a hemorrhage of fully eight ounces. He had several smaller hemorrhages previous to this date. On the sixteenth day his temperature fell to 101⅕°, remaining under 102° with but one exception, when it ran up to 103°. Temperature did not reach normal until the thirty-eighth day.

Case IV.—Caroline, æt. 5, was taken ill on January 13, three days after her mother. She started with a temperature of 104⅘. She had been listless and stupid for a week preceding her complete prostration; during the prodromata I registered her temperature twice daily, but did not find the thermometer above 100°. Two days from the last date, the fever had reached 105⅘°. From this point on it was a gradual decline for twelve days, when it as gradually climbed up to its old figure of 105⅘°. This intermitting type continued for forty-two days, when it fell below 100° and I ceased to make a record. The case was one of unusual severity, frequently losing large quantities of blood by the bowel, yet constipation was the rule throughout the illness. Epistaxis was also constant, the face being stained daily with blood; low delirium existed for over two weeks. The patient was in bed for over seven weeks.

Case V.—Katie, æt. 10, had a temperature record of her own—a marked difference existing in this case from the others. Above 104⅘° to start with, reaching 105° the same evening, remaining above 104° for *three days*, then gradually declining for three days, when it again assumed the upward tendency, holding it for three days, then came a rapid fall. This intermittent character in the temperature continued for thirty-two days. This case was obstinately constipated throughout her illness, and was but slightly delirious. Recovery slow. Six weeks in bed.

Case VI.—Pauline, æt. 14, an unusually well-developed girl, and the last case which I deem of sufficient interest to record in the history of this family epidemic, will also illustrate a different phase in temperature irregularities. Three of the children before they became actually sick were noticed to have a weary, listless expression, did not manifest interest in their play, showed a decided preference for the house, which was contrary to their usual habits.

I registered the temperature of two of the younger children for a week or more before they were stricken down, and I did not find an elevation of temperature but slightly above normal, unless the temperature was taken in the evening, when it was generally near 100°. Taking into consideration the daily fluctuation in health, which is always higher in the evening, I could scarcely draw the line between the normal evening elevation in health, and the insidious approach of the fever. With Pauline I still endeavored to anticipate the onset of the disease. Acting on the suggestion of some of my professional friends, I commenced to register her temperature nearly two weeks before I perceived any indications of her being the next to fall sick. I might anticipate any theoretical conclusions likely to find lodgment in your minds as to the causation, by stating that the girl had been employed in a dry goods store, and was brought home to take charge of the sick family. Upon her devolved most of the washing and cooking for the sick. While the younger children were out of the house nearly all day at play, she was busy with household duties, and was in this way more exposed to the infectious disease than her younger sisters, who seemed to contract it so readily. I found it most convenient to take her temperature at the time I visited the other members of the family, *i. e.*, between nine and eleven in the morning, and eight and nine in the evening. I never found her temperature above normal, until within four days before she was compelled to take her bed. Three days before her prostration, the thermometer registered 102°, normal the following day; second day it was 101⅘°; the following day it ran up until it reached 104⅘°.. Her temperature continued high for over ten days, ranging from 103° to 105°; then assumed the intermitting character so frequently noticed in the record of the other members of this family, after which the fever record had a gradual decline. By anticipating her attack of the fever, and registering her temperature for over a week, three days in which her fever was above normal, gave us part of the ascending scale of Wunderlich—yet does not supply the gradual ascent and the lengthened arc of the semicircle, which should describe the model typhoid temperature record.

I have hinted that the cause of this epidemic had a tangible existence. While it is not the object of this paper to touch upon the etiology of typhoid, yet it may not be without interest to mention the environments of this fated household. It is unusual to have seven cases of typhoid occur in one family, and follow each other in such rapid succession; yet not until the third member of the family was prostrated, could an adequate cause be found.

The head of the family was an industrious carpenter, who resided, with his wife and five children (two older girls were not living at home), in a two-storied, four-roomed house, near 13th and Columbia Avenue. The house was quite comfortable for a small family, but not so for this one; hence they were crowded. Yet I have seen families packed in, and live free from disease, when there has been actually more to a room than in this family. The cellar was dry, drainage in a fair condition. A vacant lot of enclosed ground intervened between our family and the nearest neighbor on the north. This neighbor on the north was in the milk business, and for his convenience, he had excavated a pit in the vacant lot adjoining our family's cellar-wall, four feet deep, into which he had dumped the rubbish of the yard. The rain and snow, falling upon the decomposing mass of organic material, soon found its way through the intervening stone-wall; percolated its liquid poison into the cellar. This filth, while not at all times sufficient to be recognized by the sight, was more frequently perceptible to the sense of smell. The pit could in no way impregnate the drinking water of the family, for, as a precaution, I had all the water that was consumed for that purpose brought to them from a distant neighbor.

While we have mentioned the exceptional in the temperature record, we may also entertain a doubt of this rubbish-pit being the only factor in the family illness. The first case in the epidemic, Mary, æt. 13, was employed in a store; hence she was not in the atmosphere of the house as long as the mother, who was the only one who constantly lived in the poisoned house, and yet second on the list, and, while she had a severe attack, her illness was not so prolonged as the first. Again, Pauline, the eldest girl, came from another family, in perfect health, resided for three months in the infected house, exposed to every form

of contagion, and was the last to succumb to the disease; and when finally she was prostrated, the fever ran a comparatively mild course.

In directing your attention especially to the peculiarities of temperature in the foregoing cases, that ended in recovery, I wish now to contrast them with one that, while the temperature was under control, and lower than any of the foregoing, yet without complications, it ended fatally.

A finely built young man of 27, regular, but rather full habit, first complained, August 1, of intense headache, back-ache, indifferent appetite, and general disinclination to exertion. He left the city against the wishes of friends, as well as myself, for a trip through the South. On the 3d, he was taken violently sick; sent home, reaching the city August 4. At my first visit, same day, at 12 M., temperature was 104°; at 8 P. M., 104⅝°. On the sixth day, he lost consciousness. His delirium was wild and pugnacious; constant mutterings. At the same time, his temperature fell below 104°, and remained below for over a week. On the tenth day his temperature reached 104⅝°. From this point it fell, and remained under 103° until the fifteenth day, when it ran up to 104⅝°, at death.

It is unusual to find patients unconscious when the temperature is so easily under control. In this patient the only antipyretic measure used was the cold bath. None of the symptoms of this case were as severe as the group occurring in the epidemic; yet this case terminated in death, while all of the others, indifferently nursed and badly surrounded, made good recoveries.

While it has been my principal object to record these cases typhoid, as departing in a measure from the temperature law of Wunderlich, I wish to call your attention incidentally to the following facts:—

1st. Six of the group of cases noticed in this paper were children, yet we had a severe course of the fever, and the temperature record commenced high, showing frequent irregularities. Wunderlich states, that in children, particularly in the younger subjects, the course of typhoidal temperature is somewhat irregular. The commonest of these irregularities is its extreme mildness; yet the temperature rises in the first days to a higher average than in adults; it passes more quickly into the remitting period, and defervescence is less protracted, but complications often occur, closely indicated by the temperature.

2d. In the nine cases of typhoid, including mild as well as severe examples, we had four cases of intestinal hemorrhage. An unusually large percentage. Systemic writers on fever regard intestinal hemorrhage as a rare and grave symptom. While Liebermiester states that there is not a single symptom belonging to typhoid which can be characterized as pathognomonic, yet a tendency to diarrhœa is quite frequent and intestinal hemorrhage quite rare, in our cases we found the bowels confined in over half of the cases.

Dr. Broadbent looks upon constipation in typhoid as of sufficient importance as to entitle the fever a distinct variety.

1408 N. 13th Street.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

STATED MEETING HELD NOV. 26TH, 1884.

DISCUSSION ON TYPHOID FEVER.

Dr. J. C. Wilson, in opening the discussion, said: The paper of Dr. Hollopeter is very interesting and suggestive. It touches upon or suggests almost every important clinical problem relating to this disease. Its free discussion would be impossible in one, or indeed in many evenings, Two or three points call for special consideration.

First. The typical temperature-curve, and its variations. The well-known course laid down by Wunderlich as a standard, is met with, perhaps, less frequently than strongly marked variations. Nevertheless, a knowledge of that course is the key to the understanding of the variations from it. Wunderlich, after describing the course of the first four or five days, lays down the law that every case which does not conform to this temperature type is not typhoid fever. The dictum has been the source of manifold errors in diagnosis. No more fallacious statement could be made. Cases of undoubted typhoid fever constantly occur, in which the range of temperature fails to conform to the typical curve, not only in

the beginning of the attack, but throughout the whole course of the disease. In fact, cases sometimes occur, the nature of which is fully established by the complexus of symptoms and the existence of local epidemics, in which the temperature remains throughout even *sub-febrile*. The singularly labile temperature in this disease, rising and falling, as it does, under very slight disturbing external influences, makes it a matter of surprise, not that the temperature is not always typical, but rather that it very closely conforms to the type.

Second. The inversion of the diurnal range, of which Dr. Hollopeter has given two instances, is not common. I have seen cases of it, to which I will briefly refer. I am not aware that any adequate theory of this curious clinical phenomenon has yet been advanced.

Third. House epidemics. The second part of the paper, which considers the details of this curiously circumscribed and localized outbreak, is very interesting and important. It is by the study of such house epidemics, that a true insight into the etiology of the disease is to be gained. I do not agree with the author of the paper, in ascribing the disease in the infected house to the percolation of waste water, through the cellar-wall, from the adjoining premises. In order to establish this theory, it would be necessary to show, first, that such percolation, if capable of producing this disease, had not been going on for an indefinite time prior to the attack; and second, that typhoid fever had existed in the neighbor's house, or at least that the dejecta of typhoid patients had been thrown into the pit from which the drainage into the cellar ran. These facts have not been shown. On the other hand, it appears clear enough that the first case, the young woman, who had come home sick from another house, had introduced the disease. An investigation of the house and neighborhood from which she came, would doubtless shed light upon the subject. House epidemics are numerous in Philadelphia. Certain houses, however, seem to be the abiding place of the infecting principle, seeing that cases occur in them from time to time during a series of years.

Dr. E. T. Bruen: I have been very much interested in Dr. Hollopeter's paper, and also in the remarks of Dr. Wilson. I agree particularly with the portions relating to the contagion. Two cases recently seen by me illustrate this: a washerwoman took home the clothes of a typhoid-fever patient. Within a week, her two children drooped and became feverish. They were taken to the Children's Hospital and one died there with no autopsy; the other was taken home, where it died, and I made a post-mortem examination. The typical conditions were present. No other cause was known.

I am also interested in what Dr. Wilson has said about alterations of temperature from slight causes. We notice the same thing in diseases of the liver, in which cases the thermal wave fluctuates with the injection of food. If we admit these causes, I think we can readily admit physic influences in the same role.

In diagnosing typhoid fever, it is to be distinguished from malarial fever and catarrhal fever. Malarial fever is *sui generis*, and can be controlled in this latitude by quinine. I believe that malaria will modify the initial stages of typhoid fever. Thus one of the groups of cases called typho-malaria takes its name. Neglected malarial fevers form another group of so-called typho-malarial fever, which is not a disease *sui generis*.

I have seen many cases of mild typhoid fever—the so-called typhoid ambulatorius. Throughout, these cases have shown a temperature of 100°, not over 100°, but I would not make the diagnosis of typhoid fever if the temperature after the fifth day fell below 100° in the evening.

Catarrhal fever is characterized by peculiar weakness, with various catarrhal conditions of lungs and bowels. The temperature runs from 99° to 100°, and is at times almost normal. Such cases should be classed as catarrhal fever, and are very similar to the specific forms of influenza. They may be recognized by the fact that the temperature is very irregular, and it is impossible to control this feature by quinine. I think these are the cases which have often been confused with mild typhoid.

Dr. Baldwin: Dr. Levick sometime ago published a paper in which he spoke of a family predisposition to typhoid fever, as well marked in some families as that of phthisis.

I should like to ask Dr. Wilson if he has noticed any cases of like character.

Dr. B. Trautmann: Niemeyer speaks of inverse temperature in typhoid fever, and says that these cases end, generally,

fatally. This seems to disagree with the statements made here to-night. I have at this time a case showing this curve, in which a hemorrhage of the bowels followed this morning.

Dr. Kevin: I have also a case now under treatment showing inverse temperature.

Dr. Arthur V. Meigs: With regards to the etiology, I do not think Dr. Wilson's position is well taken. In the face of the authority of Murchison, that typhoid fever may arise *de novo*, it seems to me hardly fair to assume the germ theory as proven, although the medical mind seems at present to be inclined in that direction. Typho-malarial fever has always seemed to me a bad name, for it misleads; it means, in its proper sense, a hybrid, both malarial disease and typhoid co-existing in the body at the same time.

Dr. W. A. Edwards: In the case of a young man under my care whose temperature presented the peculiarities spoken of, a diagnosis of double quotidian was made. On the eighth day, signs of typhoid fever set in, and lasted four weeks; then again there was a typical double quotidian. If the case had not been so diagnosed, it would have been put down as a case of typhoid fever with inverted temperature. This, with other cases, I published in the *Medical and Surgical Reporter*, November 17 and 24, 1883, and mention it to-night to call attention to the fact that all cases of inverted temperature in typhoid fever are not due to the typhoid entirely, but frequently to a complication, this complication occasionally being almost unrecognizable except for its effect on the temperature.

Dr. Wilson: A clear comprehension of the mode in which typhoid fever is propagated from previous cases, by means of a specific infecting principle, is of the utmost importance. Murchison, it is true, held that it might arise *de novo*. Nothing in the literature of the subject is more brilliant than that great author's advocacy of this view, but the student of the subject knows that it was asserted in Murchison's day with a vigor scarcely inferior to that with which it has been defended here, with more success. To Dr. Wilson Budd, of Bristol, is due the credit of showing that Murchison's view was untenable. To-day it is no longer entertained.

Dr. Meigs: I did not pretend to deny that a single case of typhoid fever may be the focus from which any number of others may arise. I merely contended that in the face of Murchison's opinion that the disease may arise *de novo*, we should be careful how we assume as proven, the germ theory.

Dr. J. Solis Cohen: I do not rise to speak directly to the subject of the paper, as I do not see typhoid fever except in hospital practice. Many years' observation has convinced me that sudden rises of temperature in typhoid fever, as in other diseases, are often due to obstruction of the bowels, even though diarrhœa may exist. A small dose of castor oil will usually quickly relieve the bowels and reduce the temperature. The ordinary milk diet is then to be modified by the addition of lime-water, or by substituting boiled milk for cold. My residents have for years had general instructions to pursue this plan without awaiting my daily visits.

The family epidemic recorded, reminds me of a similar one in a German family, the members of which were distributed to several hospitals, three of them coming under my own care. A marked local epidemic occurred among the sailors on board the Russian war vessels which, several years ago, were lying off the wharf at Kensington, some sixty of whom came under my care, with the most typical demonstration of the true typhoid curves that I have ever seen. The temperature charts looked as though they might have been copied from a text-book. The cause, in these instances, was the drinking of water from the Delaware River, which the sailors, following an old custom, dipped from the side of the vessel to within a few feet of the open outlets of sewers.

I was very much interested in the story of the poor washerwoman's family. Our duty, in the presence of contagious disease, is very clear, and is too much neglected by physicians. We should not allow our patients to send clothes out to be washed, until they have been thoroughly disinfected. Indeed, rather than subject a family to contagion, let the clothes be burned. Many a poor washerwoman in this city brings typhoid fever, diphtheria, and other diseases, to her household, through the carelessness or indifference of her customers.

Dr. Hollopeter, in closing the discussion, said: I had felt a certain uneasiness in pre-

senting my cases of *inverse temperature*, as I could obtain but little authority for the same, yet I have recorded the simple facts, and am glad to learn that other members have also noticed similar cases. In a future paper I hope to give more of the literature of the subject. In answer to Dr. Wilson, as to the causation of the house epidemic, I would state that Mary, the first to take sick, was, at the time, not living at home, yet she frequently came home for a few days at a time. The family she was working in were healthy.

CLINICAL SOCIETY OF MARYLAND

STATED MEETING HELD DEC. 19TH, 1884.

(*Specially Reported for the Md. M. d. Journal.*)

The Clinical Society was called to order at 8.30 P. M., the President, DR. B. B. BROWNE, in the Chair.

Dr. W. P. McIntosh read the first paper of the evening, his subject being

POLIOMYELITIS, WITH REPORT OF TWO CASES.

Dr. McIntosh said acute anterior poliomyelitis in the adult is a rare disease. He described at length the two following cases:

CASE I.—Jennie P., white female, aged 27, no history of neuropathic diathesis in family. She has a tendency to melancholia. About three years ago, after a hearty supper, she was taken with burning pains in stomach, vomiting and diarrhœa, with bloody stools. She thought she had been poisoned, and gave the history of a case of arsenical poisoning. When Dr. McIntosh saw her, her nutrition was good, she had but little pain, good use of hands and arms, but legs were small; cutaneous sensibility not impaired. She could not stand, and while sitting the legs hung dangling down; entire absence of patella reflex, feet and legs objectively cold. Flexor muscles gave no response to either electrical current.

CASE II.—Fred. M., aged 22. Family history good, and had so continued up to present attack. He was suddenly taken with violent vomiting at night; next morning he appeared very nervous, complained of pain in stomach, headache and thirst. He was treated as a case of arsenical poisoning. On the second day he began to lose flesh, and had paralysis of forearm and hand, and later of the legs; abdomen tender, bloody stools at times. He finally acknowledged taking five cents worth of arsenic. Three months after this the patient came under Dr. McIntosh's care; his general condition was anæmic. He complained of cold, with loss of appetite, also inability to use hands or feet; no impairment of sensation; no trouble with bowels or bladder; cannot close hand or flex fingers. No reaction with faradic, but slight with voltaic current. Legs small from muscular atrophy, and will not reply to induced currents.

Following the cases Dr. McIntosh gave the etiology of the affection. He thought arsenic might be put down as a cause. He had found it mentioned by no authority.

Concerning its pathology Dr. McIntosh thought the microscope had failed to decide whether the trouble is due to an interstitial or a parenchymatous inflammation. He quoted from authorities as showing the opinions held in regard to the pathology of the affection. The trouble may commence in regard to its symptoms in children, in one of three ways; it may come on suddenly, child will retire in apparent good health, and upon rising in the morning finds he cannot walk; or several attacks of fever and vomiting may come on, then the paralysis; and lastly, the trouble may creep on insidiously. In the adult the exclusive symptom is the trophic muscular lesion.

Dr. McIntosh concluded his remarks with an account of the ways in which this may be differentiated from other affections, and the duration of its existence.

DISCUSSION.

Dr. A. B. Arnold said the case of neuritis followed by sensitive and motor disturbances, reported by Dr. McIntosh, was the first he had seen. It closely resembled poliomyelitis, which is not common in the adult, only some five or six cases having been mentioned. Cases of general neuritis followed by atrophy are not common, and are difficult to diagnose. It is not easy to distinguish general neuritis from poliomyelitis by the clinical history alone; the electrical reaction is the same in both, though in the former we have no history of sensory disturbances.

PAPILLOMA OF THE BLADDER.

Dr. L. McL. Tiffany related the following case from which he removed a papilloma of the bladder. The patient was female, 27 years of age, married, and had had two children. She had passed bloody urine for eighteen months at intervals, no clots. On one occasion her attending physician found a gelatinous mass protruding from the the urethra, which he cut off. From the history of the case a tumor was diagnosed, an anæsthetic was administered, and the urethra rapidly dilated. Upon examination a growth was felt at the left part of the fundus. With the index finger in the bladder a tube was passed, and the bladder filled with fluid, a growth with five stems was found floating in the fluid. As much as possible was scraped away with the nail; the bladder was again filled and scraped with an instrument. There was but little hemorrhage; that same evening she held her water perfectly, and has had no trouble since (June 4th, 1884). After operation the viscus was washed out with warm water. The doctor laid special stress upon the filling of the bladder with fluid as a means of diagnosis.

DISCUSSION.

Dr. Branham desired to know if twisting would not have been preferable to scraping.

Dr. Tiffany said the forceps could only be made to bring away what was directly in their grasp, as he could not pinch he scraped. The pieces were about one and-a half inches long, quarter inch in diameter, and looked like red jelly. The urethra was dilated by probes of various sizes fitted to a handle, and passed in rapid succession. He though the growth benign.

Dr. N. G. Keirle said Prof. Billroth had several times in operating for stone removed papillomata from the bladder. In two cases the papilloma were thought to be malignant from an examination of the fragments passed. The doctor said he would like to be able to answer the question. How shall I decide as to the innocency of a growth? In one case that he had met with the growth occurred in an individual under 40, at which age the malignant growths are common. In a second case in a man of 60, at which age they are uncommon. It is possible you might, after a careful search get a specimen showing the pearl crypts; here it would be thought to be malignant.

Dr. Branham said Sir H. Thompson had answered Dr. Kierle's question in the *Lancet*. He simply pinches off a piece and examines it under the microscope.

Dr. Keirle said what he desired to know was what appearance, under the microscope, would enable him to diagnose a malignant from an innocent growth.

Dr. R. B. Morison thought the result in Dr. Tiffany's case was all that could be desired. Malignant growths can be cured by scraping either from the skin or mucous membrane, provided all the diseased tissue has been removed.

Dr. G. H. Rohé doubted if under ordinary circumstances a malignant growth could be thoroughly removed by scraping; a caustic must be used, but even then a recurrence is the rule. The trouble is in a thorough removal.

Dr. B. B. Browne thought that malignant disease of the female bladder was of rather rare occurrence, except in cases where it primarily affected the uterus or cervix; non-malignant polypoid hypertrophies and mucous polypi were much more common in this organ.

Dr. L. McL. Tiffany related the following: During the past year a man in middle life came to him complaining of bloody urine. An examination with the sound revealed nothing. His bladder was cut into and a finger introduced which revealed a papilloma; this was removed, but in four months the patient returned again for treatment.

Dr. R. Winslow related the following: A man 40 years of age, with a history of stoppage of urine, came under his care; after a time he succeeded in entering his bladder, each introduction of an instrument giving rise to much pain. He did not improve under injections. From the history a growth was diagnosed; it was thought to act like a ball valve in opening or shutting the urethra, which would account for his inability in certain positions to make water. A perineal section was made and finger introduced, but nothing could be found in the bladder. The bleeding soon ceased, urine gave no pain in its passage as it had done previously, and patient left apparently cured. The doctor thought the trouble due to a cystitis.

EXHIBITION OF SPECIMENS.

Dr. W. T. Councilman exhibited

A SPECIMEN FROM A CASE OF EXTREME HYPOSPADIAS, SIMULATING HERMAPHRODISM.

(See the JOURNAL of Jan. 3d, p. 174.)

Dr. R. B. Morison said he remembered having seen in Berlin a case of supposed hermaphrodism; the subject was a man in looks, but also had well-developed breasts and female sexual organs.

Dr. B. B. Browne referred to the case of lateral hermaphrodism with plates, reported by Dr. P. F. Mundé in the *American Journal of Obstetrics*, Feb. 1876. In this well known case, which was examined at nearly all the larger German clinics, and afterwards in America, the subject, Cath. Hohman, menstruated regularly, and had sexual feeling for the male sex, which she (?) gratified by cohabiting with a man for over twenty years. After the menopause, however, her (?) sexual propensities changed, and she (?) became Carl Hohman and took a wife, with whom he (?) lived happily, and performed his (?) marital duties in a manner satisfactory to both parties.

Dr. T. A. Ashby also referred to the history of a woman who for forty-six years had had her menses, and a lover. After menses stopped she lived as a man. She had been examined by Virchow. On the left side was found a testicle, on the right an ovary; no vagina, simply a cul-de-sac.

Dr. W. T. Councilman thought there was but one known case of true hermaphrodism, and that the subject was a goat.

DIMINUTIVE SPLEEN.

Dr. C. W. Mitchell exhibited a SPLEEN, which weighed only one drachm. He could give no history of the case; the individual was a large, well-nourished man.

Dr. J. N. Mackenzie exhibited specimen of growth he had removed from the posterior pillar of the fauces on left side; from their position growths are rare; also portion of upper and posterior portion of vomer, which he had removed in a case of ozœna. In cases of ozœna all necrosed bone should be removed, but the operation of turning the nose up or the forehead to reach the bones, he thought very unnecessary.

Dr. I. E. Atkinson said in the case related by Dr. Councilman he had observed during life a well-marked diastolic murmur, but that the autopsy had shown the valves to be healthy. The trouble was no doubt secondary to his renal disease. Just within the aorta was found a band of a calcareous deposit, and possibly this band so held the artery as to prevent coaptation of the valves.

Dr. W. T. Councilman said he had poured water into the heart, which the valves held.

Dr. N. G. Keirle thought there might be an inflammation of the interior of the heart, with lymph deposited upon the valves, which might cause murmur and afterwards swept away.

Dr. I. E. Atkinson thought this could not apply to his case, as the murmur was constant.

Dr. C. Johnson, Jr., exhibited a new

THROAT SPECULUM AND TONGUE DEPRESSOR

combined, of an exceedingly simple form, which had just been brought from Paris.

SALICYLIC ACID IN LUPUS VULGARIS.—In a case of lupus, in which the disease had already done much damage to the side of the nose, the cheeks, and the eyebrows, Dr. Marshall (*Algem. Wiener Med. Zeit.*) succeeded in healing the ulcer with salicylic acid. He employed an ointment containing ʒj of the acid to ℥j of vaseline. The cicatrix obtained was flexible and smooth. Altogether the result of treatment was very gratifying, and the author warmly recommends the use of the drug in similar cases.—*Med. Record.*

A CONTEMPORARY OF SHAKSPEARE.—According to the New York *Med. Record*, "In the churchyard at Fredericksburg, Virginia, is a tombstone, on which may be deciphered these words: 'Here lies the body of Edward Heldon, practitioner in physics and chirurgery, born in Bedfordshire, England, in the year of our Lord, 1542, was contemporary with, and one of the pall-bearers of William Shakspeare, of the Avon. After a brief illness, his spirit ascended in the year of our Lord, 1618, aged 76.'"

Editorial.

Mr. Lawson Tait's One Thousand Cases of Abdominal Section.—The conclusion of a series of one thousand cases of abdominal section affords Mr. Lawson Tait an opportunity for a critical examination and review of his work. Such an event is a glorious achievement for any surgeon. We are, therefore, not surprised that Mr. Tait should hasten to place upon record (*Med. Record*, Jan. 3) a surgical triumph which we believe, in its general results, has no equal in the history of surgical exploit. In the briefest way Mr. Tait gives an analysis of the series of cases in which abdominal section was employed. He draws a few general conclusions from them which may be considered as a repetition, in a great part, of the views he has expressed in previous reports.

Mr. Tait finds it difficult to define the exact meaning of the term abdominal section. The commonly accepted view is that an operation is not an abdominal section when the peritoneum is not opened. With certain exceptions in favor of herniotomy, removal of the kidney, or opening of the colon, in which, by accidental peculiarities the abdominal section might or might not be made, Mr. Tait follows the definition indicated by the involvement of the peritoneum.

The groups of cases appear as follows: Exploratory incisions, 94 cases, 2 deaths; cystomata, 405 cases, 33 deaths; removal of appendages, 307 cases, 17 deaths; hysterectomy, 54 cases, 19 deaths; opening abdomen for draining pelvic abscesses, etc., 85 cases, 15 deaths; extra-uterine pregnancy, 11 cases, 2 deaths; hepatotomy for abscess and hydatids, 12 cases; tumors of omentum and mesentery, 5 cases; adhesions relieved, 2 cases; umbilical hernia, 4 cases; scirrhous tumor of abdominal wall, 1 case; suprapubic lithotomy, 1 case, no deaths; enterotomy, 8 cases; chronic peritonitis opened and drained, 7 cases; acute peritonitis, 1 case; Cæsarian section, 1 case; enucleation of myoma, 1 case, each followed by 1 death. Total 1,000 cases; deaths, 93.

The first point to attract attention is the death rate, 9.3 per cent. No such series as this has before been published, and therefore Mr. Tait confesses that he cannot say whether it is too high or too low. He thinks it high, and is perfectly certain that if he lives to complete another such a series it will have a much lower mortality.

The reasons given for such a favorable view are more than satisfactory; they are correct and convincing. The present series contains Mr. Tait's early work. It is in this series that this bold, original and skilful operator entered a new field in surgery; explored and developed a virgin soil which has borne such a harvest of rich results. It is here that the want of experience has told heavily. Mr. Tait contrasts the results of his first series of fifty ovariotomies (38 per cent. mortality) with his last three hundred and thirteen cases (4.76 per cent. mortality) to indicate the terrible influence of his want of experience, though he says that whilst other factors enter into the explanation of this great difference, the influence of experience is everywhere visible. He repeats a former statement, "that in this branch of our art, more, I think, than in any other in the whole field of surgery, does the personal experience of the operator, gained by failures and hair-breadth escapes, serve him in good stead for his subsequent work."

A second reason given by Mr. Tait for predicting a much lower death rate in his subsequent operations is that important causes of failure have been completely removed by the discontinuance of the clamp in ovariotomy and of the ligature in hysterectomy; again, cases of all kinds are now operated upon at earlier stages of these diseases than when he first began his work. Mr. Tait's experience with the clamp fully justifies the conclusion reached in regard to this method of treating the pedicle, and warrants a statement made a short time back (see Md. Med. Journ., p. 165, vol. xii, No. 9) that abdominal surgery would have been half a century in advance of its present position, had the clamp never have made its appearance.

The first group of cases in the series gives ninety-four exploratory incisions with two deaths. These incisions were made for the purpose of ascertaining exactly the state of matters inside the abdomen and settling any doubt as to the diagnosis and prognosis in each case. In this method of dealing with abdominal diseases Mr. Tait has stood almost alone. He has been the daring and adventurous champion of a procedure which must come into more general practice than at present. Mr. Tait repeats what he has said many times before,

viz., "I make exploratory incisions to be sure that I am not, whereas, formerly, I used to make them only to find I was entirely mistaken. They serve the purpose of complete tappings, and, as the patients almost uniformly recover, they do no harm at all. There are two deaths recorded in this group, but I might have eliminated these two cases with perfect fairness, for one died really of the prolonged sickness after the anæsthetic, a broken-down old woman of sixty, and in the other I passed a trocar into the irremovable tumor, so that the operation was not strictly limited to mere exploration."

Nearly fifty of the cases of exploration amounted to merely a tapping. The results of this method of exploring the abdomen have been most satisfactory. The remainder of Mr. Tait's report is devoted to a review of former statements quite familiar to the readers of recent journal literature.

We cannot close our notice of this remarkable statement presented by Mr. Tait without venturing the assertion that the facts here presented have no parallel in the domain of surgical achievement and that they mark an era in the progress of abdominal surgery as brilliant and as promising as the era which gave to humanity the discovery of the circulation, or of vaccination, or of anæsthesia.

Mr. Lawson Tait on the Best Anæsthetic for use in Abdominal Surgery.—Mr. Lawson Tait takes occasion, in connection with the report of a series of one thousand cases of abdominal surgery, to which attention has been called in the foregoing article, to discuss the subject of anæsthetics in abdominal surgery. The large experience of this surgeon lends a practical value to his suggestions. Like all pupils of Simpson, Mr. Tait says he began his professional life with a profound belief in the advantages of chloroform over all other anæsthetics. He has never seen an accident from chloroform, but partly by reason of the fear of inquests and partly by the example and teaching of Dr. Keith, a belief grew in his mind that ether was preferable to chloroform. He was, however, not long in discovering that ether has special risks for people with a tendency to bronchitis, and later on he discovered that during the administration of ether the secretion of urine is completely arrested. He therefore regards ether a dangerous anæsthetic for patients with damaged kidneys. The first alteration of his views concerning ether was to limit its application to patients under forty, but even after this his confidence in its safety greatly diminished by the fatal occurrence of bronchitis in a case of hysterectomy in a woman aged thirty. In this patient breathing was embarrassed from the moment she recovered from the anæsthetic, and she died on the fourth day from suffocative catarrh. After an experience with bichloride of methylene and methylene ether (generally known as Richardson's mixture) not altogether satisfactory, Mr. Tait began to use a mixture of two parts of ether and one part of chloroform, given by means of Clover's apparatus. This mixture he found rapid in its action, not at all unpleasant to the patient, and provocative of less sickness than anything he has ever used. Mr. Tait does not think it more safe than other anæsthetics, for he is quite certain that with none of these drugs will there ever be absolute security against accidents. He has seen no bronchitis after its use; it has no effect in arresting the secretion of urine, and upon the whole he is better pleased with it than with any other.

Boston Medical Library.—The publication of the Ninth Annual Report of the Boston Medical Library Association recalls the rapid growth of the library connected therewith and the great energy and liberality displayed in its development. The collection now embraces 14,699 volumes and 12,289 pamphlets, the increase being at the rate of nearly 1,600 volumes a year; and 328 journals and transactions are received regularly. The entire library is now available for consultation, a lady having been employed exclusively in preparing a catalogue for some years past. The expense incurred under this head was borne mainly by one individual, the late Dr. Calvin Ellis, whose contribution amounted to over $1,000. An increased income during the past year has allowed the expenditure of money for various useful objects, as binding about 1,000 volumes, repairing drains, improving the heating and ventilation of the building, purchase of new volumes, etc. A circulating department of recent publications has been organized to members, who have access by paying five

cents per day for each book taken out. Among the additions recently made are several libraries of deceased physicians, a number of portraits, busts, etc. In many cases the additions made have been bound at the expense of the donors. The entire collection of periodicals and a great portion of the books of the Harvard Medical School have been received in exchange for duplicates. The collection of autographs has been recently undertaken by the Librarian with the result of adding several thousand letters to the Library's stores.

A remarkable activity has been displayed of late years in building up medical libraries in this country. The most remarkable instance of rapid growth is the Library of the Surgeon-General's Office in Washington, due to the ceaseless and untiring energy of Dr. Billings. But a comparison of the results achieved by him with private efforts would be unjust to the latter. Of the various cities which have entered more or less zealously into competition in building up medical libraries the palm for successful results must undoubtedly be given to Boston.

To have collected 15,000 volumes and 12,000 pamphlets in one's own building within the space of nine years argues much for the literary taste and capacity of the profession of that city. We will not cause offense by naming a certain not very remote city which, in fifty odd years, has been able to collect only 4,000 volumes in an up-stairs rented room.

A New Method for the Collection of Urine.—At the meeting of the Academy of Medicine, held Dec. 16th, 1884, Dr. Uhler drew attention to a plan for the differential diagnosis of affections of the urinary organs that he has been using for some years. It consists in the examination of *three* specimens of urine instead of one, collected as follows: Three receptacles carefully cleansed are placed in a row, and the patient is required to void about one-third the excretion into the first, then rapidly passing to the second he relieves himself of nearly all the remaining bladder contents, but reserves the dregs or last half ounce for the third. The urine is now put in three separate clean bottles labeled 1, 2, 3, and examined at leisure. The object is to wash away the contents of the urethra or outer part of the vagina by the first urine that passes, so that the remainder may not be contaminated by discharges. Thus, if pus or blood comes from the external parts it will only be present in large quantity in the first specimen, unless active hemorrhage be taking place, and will be found less or entirely wanting in the others. The second bottle contains the average contents of the bladder, and the third is apt to consist more largely of sediment. Thus, aided by the microscope, we are enabled to diagnose by exclusion where pus or blood comes from and can treat intelligently. For life insurance cases it is of much importance and should be resorted to as a *matter of routine*, making the person to be examined, when possible, pass the urine in our presence. When but one specimen of urine is examined that in No. 2 is to be preferred.

Book Notices and Reviews.

The Elements of Physiological and Pathological Chemistry. By T. Cranstoun Charles, M.D. Philadelphia: Henry C. Lea's Son & Co., 1884. 1 vol., 8vo., 463 pages. Thirty-eight wood cuts, one chromo-lithograph and an index.

This treatise is divided into four books, relating: 1. To nutrition and foods. 2. Digestion and the secretions. 3. The chemistry of the tissues, organs and remaining secretions. 4. The excreta: fæces and urine.

It is intended as a practical manual for students and practitioners, and contains those things that are most serviceable in a laboratory guide.

In the first chapter the author gives a list of apparatus and reagents, and briefly tells how to prepare and use them. He then discusses nutrition, dwelling upon the energy that food produces, and the importance of a constant supply of oxygen.

Following this comes a general account of foods, with a *definition*, page 45, that is very inelegant, and then a table showing how alimentary substances ought to be classified.

The next few chapters describe nitrogenous vegetable and animal substances, besides fats, carbo-hydrates and minerals, and the results of their deficiency.

The remainder of the book is filled with details of alcohols, fatty acids, blood, the tissues in health and disease, the secretions, excretions, etc., but the most interesting parts to a general practitioner, are the chapters upon albumen, fermentation, digestion, and the examination of urine. Here the author is at his best, and though he admits some things that are superfluous, and neglects others that seem desirable, yet upon the whole his task is well done.

As a *compilation* the book has merit; and type, binding and illustrations are worthy of the firm that publish it. The author in many places shows that he knows how to write well, but occasionally lapses into repetitions, and badly constructed sentences that are by no means agreeable. The information, however, is accurate, and we would advise all who are not familiar with French and German, especially if unprovided with large treatises, to buy it, and hope that the edition will be so rapidly exhausted as to justify the author in improving it by pruning and minor additions, so as to entitle it to a place beside Burdon-Sanderson's Hand-book, and the dictionary near the desk of the thoughtful.

J. R. U.

Modern Medical Therapeutics. A Compendium of Recent Formulæ and Specific Therapeutical Directions, from the Practice of Eminent Contemporary Physicians, American and Foreign. By Geo. H. Napheys, A. M., M. D. Edited by Joseph E. Edwards, M. D., and D. G. Brinton, M. D. Eighth Edition. Enlarged and Revised. Philadelphia: D. G. Brinton. 1885. Pp. 629.

The Physicians' Daily Pocket Record. Comprising a Visiting List, Many Useful Memoranda, Tables, etc. By S. W. Butler, M. D. Nineteenth Year. New and Revised Edition. Edited by D. G. Brinton, M. D.

School Hygiene in Relation to its Influence Upon the Vision of Children, or School Sanitation. An Address Delivered Before the Medical Association of Georgia, 1884. By A. W. Calhoun, President, Atlanta, Ga.

Prospectus of the Medical College of America, Session of 1884-'85. Revised to December 20th, 1884. Illinois State Board of Health.

Miscellany.

Intermediate Hospitals for the Treatment of Acute Mental Diseases.—The nervous system has of late years claimed the attention and study of the best medical minds of all countries, and it is now an evidence of a still further progress in this direction, that mental diseases are no longer allowed to remain in the hands of asylum-superintendents, but are beginning to demand the care and investigation that they undoubtedly deserve from a larger and more active class of specialists. It is by the medium of this development that Dr. John Van Bibber, of Baltimore, has been led at various periods, during the past five years, to investigate the plan of treatment and the management of insane asylums, both in this country and in Europe, the results of which are given in a most interesting paper in the January number of *The American Journal of the Medical Sciences.*

It is a curious tradition, which is blindly accepted by most people, that insanity differs entirely from any other form of disease, that it must be removed from sight, and, if possible, from remembrance, and treated only by medical men who live within the walls of an asylum, and devote their lives to the care of this class of patients. No less is it a matter of general belief that the institutions in which this malady is treated are not hospitals, but asylums, that their use and purpose, though known, are in some way mysterious, and that their existence stands outside and apart from the ordinary ministrations of men.

This uncanny reputation is clearly the result of prejudice, and to some extent the result of the present system of treating and caring for a most unfortunate class of sufferers. It is the remnant of that feeling which, years ago, built prisons for the safe-keeping of lunatics, and which employed chains and manacles in the treatment of their disease. We have developed safely beyond that dark period, and, with rare epoch exceptions, we have even passed the of restraint.

But there are other changes which are as necessary and imperative to secure the better and more successful treatment of cases of acute insanity. These changes must affect many of the characteristic arrangements of insane asylums, the medical officer

in his double rôle of physician and superintendent, and the crowding of large asylums with acute and chronic cases. This reform must also bring about the establishment of intermediate hospitals for the treatment of acute cases, and the gradual development of large asylums into homes for incurables and chronic cases.

These points Dr. Van Bibber ably discusses separately and in detail, and he comes to the conclusion that many of the evils to be complained of in our asylum system arise from the unwise association of the curable with chronic cases, and the remedy is to be found in the establishment of the intermediate hospital which is to stand between acute insanity and the asylum. This is the hospital which is to develop the ambition of the specialist, which is to enlarge his horizon, and to bring him out of an asylum into the active world of thought and progress. This is the hospital which is to teach the treatment of insanity as it has not yet been taught, and to educate, under active clinical instruction, the men who are to be the guardians and promoters of a most important reform. The possibility of making a hospital and a school out of what has been heretofore an asylum without educational power, or without the means of using valuable clinical material, is a proud future to look forward to. It means much to the profession. It is of deep significance to the public. It means an assurance that patients confided to the care of the intermediate hospital are to have every advantage of active treatment and good nursing. It means a course of treatment which will divert and distract the patients as much as possible from their sufferings, forcing them by activity to brood as little as possible over the dreary melancholy of their disease. It means the exclusion of every factor that can militate against the recovery of a patient, and the least possible detention after recovery.

Cocaine in Genito-Urinary Procedures.—*Dr. Fessenden V. Otis*, or New York, gave in the *N. Y. Med. Journal*, Dec. 6, the result of the use of the hydrochlorate of cocaine in various genito-urinary troubles. Nov. 7th he dropped a few drops of a two per cent solution into the first inch of a very sensitive urethra, holding it in ten minutes. He then dilated the orifice from twenty-seven to thirty-one m. m., preparatory to litholopaxy. Although very hyperæsthetic, the patient gave not the least evidence of pain. November 11th a patient came, suffering agony from frequent and difficult micturition. The previous attempted introduction of instruments produced intense pain. Visical tenesmus lasted five minutes after passing a few drachms of urine. Dr. O. then injected with a syringe fifteen drops of a two per cent. solution, pressing it back and retaining it for ten minutes; this was repeated, and at the end of the second ten minutes a Thompson's silver searcher was passed through the urethra, detecting calculous material *en route* and a calculus in the bladder. A large-sized Thompson's lithotrite was then introduced through the meatus urinarius which was contracted and adherent to the prepuce. Two strictures were also met just within the meatus. These were passed and a second stone found in the bladder. The lithotrite was then withdrawn, the preputial orifice freely divided with a bistory, also the meatus and strictures; not the least flinching or pain was observed. A two per cent. solution was also applied to a hyperæsthetic urethra associated with enlarged prostate, and a catheter introduced and the bladder washed out without the least pain. In a similar case the bladder was examined for the stone without complaint of pain. Into a fairly tolerant urethra he introduced a four per cent. solution to a depth of four inches, and after retaining it ten minutes divided with a dilating urethrotome a dense stricture one-half inch broad and five minims thick without the slightest sense of pain during or after operation.

Dr. O. recommends in such cases to attach a tight-fitting half-ounce penis syringe to an open-end rubber catheter, 18-20 m. m. in circumference; after pouring the solution into a small graduate draw a sufficient quantity into the catheter, introduce it an half-inch, or until the patient complains of pain, then press down the piston gradually, driving a few drops in advance of the catheter, rubbing it along with the finger, waiting three to five minutes, then passing it down two inches further and repeating the rubbing until the catheter enters the bladder; about fifteen minutes being consumed in all. He has also had very satisfactor results from a four per cent. solution in almond oil used as a lubricant for ureth-

ral instruments. The value of cocaine will be found equally great in examinations and operations upon the irritable anus and rectum.

Poliomyelitis Anterior in Adults.—Dr. Gustavus Eliot, of New Haven, records, in *The American Journal of the Medical Sciences* for January, a carefully noted case of poliomyelitis occurring in an adult. The progressive development of muscular weakness, unattended by febrile symptoms, but accompanied by diminution of the size of the limbs, by abolition of the patellar tendon reflex, and by sensations of numbness, yet without loss of tactile sensation, and without interference with the function of either the rectum or bladder, rendered the diagnosis clear and indisputable.

A large proportion of the reports of cases which have been published contain little or no information concerning the details of treatment, and in many others the multiplicity of drugs prescribed renders any reliable conclusions in regard to the effect of each almost impossible. Bromide of potassium, belladonna, strychnia, ergot, and iodide of potassium have been most often employed, and most praised. Counter-irritation, baths, rubbing and exercise, and electricity are also included as important elements in most plans of treatment. From a careful study of the results of various plans of treatment as reported by various observers, Dr. Eliot deduces the following conclusions:

First. Counter-irritation and ergot should be employed early in every case. *Second.* Massage and electricity should be used as soon as there is any evidence of improvement. *Third.* Little, if any, effect can be expected from iodide of potassium. *Fourth.* Belladonna and the bromides should be used only with extreme caution. *Fifth.* Strychnia should be entirely avoided.

Salicylate of Sodium in Malaria.—Not long since, salicylate of sodium was highly recommended as a preventative in yellow fever. This fact induced Dr. von Kirchbaur, assistant physician of the 16th Infantry Regiment of the Prussian Army (*Allg. Med. Centr. Zeit.*, November 5, 1884) to try the remedy in a case of intermittent fever which had baffled his skill for several months. Every possible preparation of the Peruvian bark, all its alkaloids and arsenious acid—these administrated in large doses and enormous quantities—had been tried in vain. The patient was a woman, and the fever had the quotidian type. K. advised her as a last remedy to take sixteen grains of the salicylate of sodium in lemon-juice about an hour or two before the expected febrile seizure. After the very first dose the attack was much milder than it had generally been; the second seizure omitted, and after the seventh dose—daily one such dose having been taken—the intermittent fever had left and not returned at the time of publication, three months later.

Several months ago we published in the *Med. and Surg. Reporter* a series of observations regarding the effect of salicylate of sodium, and mentioned at that time that it was a very safe remedy, more reliable than quinine as a febrifuge, almost tasteless, easily soluble in water, and never causing tinnitus aurium. We then recommended more extensive trials in malaria, and we again do so to-day.—*Med. and Surg. Reporter.*

Use of Cocaine in Dysphagia.—A man, æt. 45, was suffering from tubercle. There was extensive swelling and brawny infiltration of the epiglottis, but only moderate dulness and slight crepitation at the apex of the right lung. He had been treated as an out patient in the laryngological clinic for three months, and iodoform and morphia blown daily into his larynx, and he had constantly taken ice. In spite of this he affirmed that for two months he had been only able to swallow the minutest quantities of milk. He was extremely wasted, incapable of work, scarcely able even to walk, and tortured by continuous pain and thirst. Being asked to drink some water, he had hardly swallowed a drop before he started up in the greatest pain, while the water returned through his mouth and nose. I then carefully painted the lingual and part of the laryngeal surface of the epiglottis with a ten per cent. solution of cocaine, and a minute afterwards told the patient to drink again. The man anxiously took a small mouthful, for a moment looked around in astonishment, and then to the surprise of all greedily swallowed the whole glassful at a single draught. Tears of gratitude filled his eyes, and he could scarcely

find words to express his thanks. The next day he related that on reaching home an hour after the application he had, to the astonishment of his wife, made an excellent meal (the first for two months) without any difficulty, but that soon after the pain reappeared, and three hours after the painting was as bad as ever—*Jelinek. Wien. Med. Woch., and Med. Times and Gazette.*

Skim Milk in Diabetes Mellitus.—Dr. J. Lindsay Porteus does not seem to think that the treatment of diabetes mellitus with skim milk has received the attention that it deserves, and he therefore publishes a paper on the subject in the *Edinburgh Medical Journal*, Dec, 1884.

Skim milk diet, as recommended by the late Dr. Donkin, has, in his hands, proved very successful. To do good, it requires resolution and much self-denial on the part of the patient to throw aside all the good things of this life, and live on skim milk, and nothing but skim milk. At first the patient eagerly catches at the chance of relief from the excessive thirst, parched skin, and other tortures, and steadily determines to take the skim milk, but as a rule, on the fourth or fifth day he begins to tire of it, and, as in one case under his observation, the sight of it made the patient vomit. Fortunately in some cases a little kindly encouragement helps him to overcome his dislike, and with renewal of the remedy a cure is effected. He has seen much good, but never a cure by the codeia treatment. The drowsy and languid feeling which it causes, are sources of great annoyance and depression to the patient. The sp. gr. and sugar are often decreased by it, but the latter never entirely leaves. The same remarks hold good with regard to opium.—*Med. and Surg. Reporter.*

Injection of Finely Powdered Inorganic Material into the Abdominal Cavity of Rabbits does not induce Tuberculosis.—When Koch first announced to the world his discovery of the tubercle bacillus, and gave an account of the experimental evidence which had convinced him of its essential etiological relation to the disease tuberculosis, it was natural that conservative physicians should demand additional evidence and confirmation from other sources before accepting his conclusions, notwithstanding the reputation which he had already established as an expert and conscientious investigator. Hence Dr. George M. Sternberg was lead to study the *modus operandi* of the bacillus in producing tuberculosis, and ascertain whether its pathological power resulted from its simply acting as a mechanical irritant or depended upon specific physiological characters peculiar to it. The result of his important investigation, which was made in the biological laboratory of the Johns Hopkins University, appears in the January number of *The American Journal of the Medical Sciences.* He injected into the peritoneal cavity of a number of rabbits thoroughly sterilized, powdered glass and marine blue, taking every precaution to avoid the dangers and possibilities of accidental infection, and the results gave no support whatever to the claim that tuberculosis may be induced by the presence of finely powdered inorganic particles, or to the view that the tubercle bacillus induces tuberculosis by acting simply as a mechanical irritant.

Caution in the Use of Cocaine.—*Dr. Knapp* (*Med. Record*, Dec. 13, 1884,) says that he injected six minims of a four per cent. solution into the orbit close to the posterior segment of the eyeball. The anæsthesia was complete, and the operation and and recovery were without any disturbance. During the operation the patient's face became pale. The patient did not, however, complain. Again he injected five minims of a three per cent solution beneath a sebaceous tumor, the size of a small walnut, in the centre of the upper lid. The anæsthesia was almost complete, and the somewhat laborious operation passed satisfactorily, but during it the patient became as pale as a corpse, felt somewhat faint, asked repeatedly for drink and was covered with cold perspiration. In about fifteen minutes the condition, which was in no way alarming, disappeared. Though much larger doses have been hypodermatically injected before general symptoms were apparent, Dr. K. thinks that five or six minims of a three per cent. solution may be too much for the orbit. The orbital cellular tissue is so vascular that it resembles cavernous tissue. Liquids injected it into may enter the general circulation more readily than from other parts. In further operations he would inject no more than one or two minims and gradually feel his way.

A Tumor Caused by Retained Fæces Mistaken for Cancer of the Liver.—*F. Boureman Jessett*, F. R. C. S., relates the case of a lady (*Brit. Med. Journ.*) who had been under the care of one of the most illustrious London physicians for supposed cancer of the liver. When she came under his care she was within a few hours of her end; she had a large tumor, extending from the right iliac fossa, occupying the whole right iliac and hypochondriac regions, extending forwards over the epigastrium and occupying the greater part of the left hypochondriac region. The tumor was hard, smooth and tender. The patient was suffering from vomiting and when he saw her was in a state of collapse. The bowels had been open with slight liquid fæces. He immediately suggested that the physician under whom she had been should see her, which he did the same morning. The latter then told him that the patient had cancer of the liver and would die in the course of twenty-four hours; at the end of that time, however, she was alive and another physician was called, who corroborated in every particular the diagnosis of the former physician. Dr. J. then obtained permission to give large enemata under the idea that the patient was suffering from a loaded colon. In less than a week the tumor had entirely disappeared and the patient is now alive and well. Had an aspiratory needle been used in this case the true nature of the case would have been made known to the first attendant and the patient's life not been put in jeopardy by lack of proper treatment.

Obstetrical Society of London on Treatment of Vomiting of Pregnancy.—Dr. Hewitt thought it due, like most other diseases peculiar to women, to flexion or version. Dr. Hicks called attention to the great value of morphia. Dr. Matthews Duncan called attention to researches of Hecker and others into degeneration of liver and kidneys associated with pregnancy and also the association of severe and intractable vomiting with such changes. The cases of fatal vomiting he believed to be of this kind, and he drew a distinction between such "pernicious" vomiting dependent upon degenerative changes and ordinary vomiting of pregnancy which, though often severe, is never fatal, and is so conspicuous in its onset and decline that every remedy used is sometimes followed by cessation of vomiting. No drug or any other treatment can be relied on to cure, and only weak-minded persons can regard the occasional cessation after treatment as proof that the treatment causes it. The drug that seemed to him to do most good is atropia, and he endorsed Dr. Hick's praise of morphia.—*Med. Times and Gazette.*

Thallin—Another Antipyretic.—The *Medical Press*, November 26, 1884, thus refers to it:

"Dr. von Jaesch, of Vienna, has recently stumbled on still another synthetic antipyretic, which he introduced to the notice of the Society of Physicians of Vienna, on October 31st, the chemical name of which is zetrahydroparachinanizæ. The name no doubt is an excellent one for ceremony and great occasion; but recognizing that life is short, and not to be all spent in pronouncing names, he has mercifully given it the shorter one of thallin, by which it will be sufficiently well known if it proves to be worthy a name at all. He has already employed it in 86 cases of pyrexia of various kinds, viz., pneumonia, typhoid, erysipelas, measles. The fever was cut short with certainty, and without any disagreeable bye-effect, but the effect upon the course of the disease was in other respects nil.

"In doses of ¼, ½, ¾ gm. the temperature fell several degrees. Of the various salts of the drug enumerated by him—sulphate, tartrate, hydrochlorate—he recommends the first-named for clinical purposes, and suggests that it may well be employed when all other antipyretics have failed."—*Med. and Surg. Reporter.*

Cases Suitable for Aspiration.—*F. Bowreman Jessett*, F.R.C.S., in *Brit. Med. Jour.*, enumerates the following as diseases in which aspiration may be employed with success:

1. Fluids accumulating in serous cavities: hydrocephalus, hydrarthrosis, pleurisy, empyema, pericarditis and effusion into synovial cavities.

2. Fluids formed in deep parts of organs: abscesses in hydatid tissues of lungs or liver, cysts of spleen, omentum, ovarian cysts, retention of urine, strangulated hernia.

3. Liquid formed within the cellular tissue of various regions: congestive abscess,

bubo, perinephritic abscess, iliac or psoas abscess, peri-uterine abscess.

4. Collection of air or gases in cavities or organs: pneumothorax, tympanites and strangulated hernia.

5. Removal of *débris* from the bladder after lithotrity, and diagnosis of tumor in the bladder.

Medical Items.

Cocaine is used for painless filling of teeth in New York.

During the year 1884 the Six Faculties of France produced about seven hundred doctors.

Prof. Virchow has had a severe attack of gout cured by a course of Carlsbad water—and time.

Dr. Thomas, of New York, says that among drugs the permanganate of potash is the best emmenagogue.

The Ohio State Sanitary Association will hold its second annual meeting at Columbus on the 5th and 6th of February.

Dr. J. P. Smith, of Clarke County, Va., died December 29th, of paralysis. He was a surgeon in in the Confederate army.

Dr. F. A. Burrell has used in hemorrhoids with alleviation of pain an ointment made of coca leaves, heated lard and an alkali.

Sir William Jenner, of London, commenced life as an apothecary in a small back street, and for a long time the battle of life fell severely on him.

Dr. Christopher Columbus Graham, of Louisville, Kentucky, recently celebrated his hundredth birthday in the enjoyment of a banquet tendered him by his neighbors.

Dr. Geo. H. Atkinson, a prominent surgeon of Brooklyn, N. Y., died recently from blood-poisoning, contracted whilst operating upon a patient who was suffering with syphilis.

William Darling, M. D., F. R. C. S., the eccentric Scotch Professor of Anatomy in the Medical Department of the University of the City of New York, died of pneumonia, December 24th.

Dr. von Wittich, who, on account of illness, was obliged to resign his professorship of physiology at Königsberg, and was succeeded by Prof. Hermann, has recently died in the 64th year of his age.

Dr. Allan (*Br. Med. Journal*) reports fifty cases of pulmonary affections in which cough was a distressing symptom. He employed subcutaneous injections of ergotin with signal relief in most instances.

The students of the 2nd, 3rd and 4th years in McGill Medical College, recently presented Prof. Osler with a handsome gold hunting-case watch as a slight token of the high esteem in which he was held by them.

The first essential in the intelligent use of the pessary and for the avoidance of its abuse is a correct diagnosis; and the second is an understanding of its action. Without these nothing but confusion and probably injury can follow.—*Bantock.*

A bill has been prepared for presentation before the legislature of Pennsylvania during the present winter, having for its object the establishment of a permanent commission, to be known as the State Board of Medical Examiners and Licensers, which shall have the power to pass upon the qualifications of all physicians seeking to practice medicine or surgery in the State after September 1, 1886.

Prof. William Darling, whose death has been announced, was an eccentric old bachelor who lived at the University building in the most simple and unpretentious way. He regularly left the college at three o'clock every afternoon, and walked on foot to and from Rolfe's chop-house, in John Street, where he dined. He took pride in living on a ridiculously small sum per diem, and in this way he amassed a considerable fortune.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from Dec. 30, 1884, to Jan. 5, 1885.

Girard, A. C., Captain and Assistant Surgeon, ordered from Department Mo. to Department East.

Appel, A. H., Captain and Assistant Surgeon, granted leave of absence for one month to take effect on or about January 7th, 1885. (Madison Barracks, N. Y.)

Ewing, Chas. B., First Lieutenant and Assistant Surgeon (Fort Stanton, N. M.,) granted leave of absence for two months.

Original Article.

REPORT OF LAWS REGULATING THE PRACTICE OF MEDICINE IN THE UNITED STATES AND CANADA.*

BY RICHARD J. DUNGLISON, A.M., M.D., OF PHILADELPHIA, PA., AND HENRY O. MARCY, A.M., M.D., OF BOSTON, MASS.

Since the last Annual Report of your committee was presented to the Academy, at its meeting in New York, in October, 1883, but little change has been effected in the legislation already operative in many of the States, or in the introduction of new laws regulating the practice of medicine in States or Territories in which the public were not already legally protected. Virginia is the only State in which a Legislature has, during the year past, contributed anything of general or special interest to the sanitarian or humanitarian in the restriction of unqualified practitioners.

In some of the States and Territories the Legislatures meet biennially, and have not, therefore, had the opportunity offered them of passing such measures as are urgently demanded in the interest of the public health. Whether they would accomplish anything remarkable in this direction, even if the most abundant opportunities were available, it would be impossible for any one, familiar or unfamiliar with the general uncertainty and crookedness of methods of legislation, to conjecture.

Under these circumstances, there being so little for your committee to report in regard to additional legislation restrictive of medical practice, it has seemed to them that it would be appropriate to take a brief glance at the present condition of the laws bearing upon the subject, and to secure an expression of the views of those actively interested in the various sections of the country in their efficient working. With this object an extended correspondence has been entered into with Governors and Secretaries of States and Territories, with Secretaries of State Boards of Health and of State Medical Societies, and with other gentlemen interested in measures of public sanitation, and the replies elicited offer an excellent medium for an intelligent appreciation of the condition of State legislation, at the present moment, on this important subject.

Dr. J. L. Cabell, of the University of Virginia, President of the National Board of Health, who kindly furnishes a copy of the new law, makes reference to the fact that in Virginia—

"Prior to the passage of this Act any person who chose to call himself a physician, and was assessed with a license tax as such, had any privilege that was accorded to regularly graduated physicians. The new Act has some defects, which it is hoped may be corrected by future legislation, but has one great merit, in requiring *all* candidates for practice, *whether graduates or not*, to undergo an examination by the Board of Medical Examiners, to be appointed by the Governor, on the nomination of the State Medical Society."

Dr. James E. Reeves, Secretary of the State Board of Health of West Virginia, asserts that—

"No statute passed by a legislature was ever more heartily welcomed by the whole people than has been the law regulating the Practice of Medicine and Surgery in West Virginia. Its operation from the date of its passage, March 8th, 1881, to the present, has been a continued success—a blessing to every citizen of the State, and a strong arm to uphold the dignity of the medical profession within our borders. No changes in the law are contemplated by our Board. We are satisfied to 'let well enough alone.'"

Dr. L. Julian Picot, Secretary of the State Medical Society of North Carolina, mentions, as a feature of the law in force in that State, that under its provisions—

"Practitioners are not allowed to collect bills by legal process unless licensed by the State Board of Medical Examiners. The Board is elected every six years by the State Medical Society. The present law is not satisfactory to the better class of the profession, nor will it be until it is made a misdemeanor to practice without a license. An effort will be made to secure the passage of an Act to this effect. If successful, then the profession of this State will be happy."

Dr. A. S. von Mansfelde, Permanent Secretary of the Nebraska State Medical Society, writes as follows:—

*Read before the American Academy of Medicine, at its Annual Meeting at Baltimore, Md., October 29th, 1884; approved for Publication by the Council.

"The law, as it now exists, is inoperative, because any infringement upon it becomes a criminal offence, the common law providing that, in such cases, the defendant shall be faced by the witnesses of the prosecution. To procure witnesses from distances, the places where bogus diplomas are manufactured, as, for an example, Philadelphia, Cincinnati and St. Louis, would involve a cost to which neither individuals nor societies are equal; therefore, the failure of a law otherwise good enough. I shall surely introduce the Illinois law at the coming session of our Legislature, January, 1885, and have some hope of its passage."

Dr. C. C. Fite, Secretary of the Medical Society of the State of Tennessee, states that—

"There are no laws of any kind on medical practice in Tennessee, and not likely to be soon, as the profession in this State is divided on the question. We have received a considerable addition to our ranks recently, by the enforcement of laws in other States forcing the 'ne'er do wells' to seek more hospitable climes, and Tennessee welcomes them all."

In commenting upon the working of the law regulating the practice of medicine in in the State of Louisiana, Dr. Lucien F. Salomon. of New Orleans, writes thus intelligently and fully:—

The act now in force has several defects, which it would be well to point out.

"In the first place, section 3 allows the privilege of registration to persons who have been practicing in the State for more than *five* years prior to the passage of the act, regardless of qualification, and the result has been that every charlatan, quack, and unqualified person who pretends to practice medicine, or styles himself 'doctor,' has hastened to take advantage of and profit by this privilege, while many regular physicians, possessing diplomas from reputable colleges, have either refused or neglected to register; the neglect or refusal being, in great measure, due to this provision, which places upon an equal footing with them irregulars, 'herb doctors,' quacks, and impostors. Out of a total of 1027 physicians in the State of Louisiana, 758 have registered, of whom 141 are without diplomas, and have been *legally* registered, after having made affidavit of five years' practice. In the City of New Orleans there are about 270 persons practicing or claiming to practice medicine. Of these, 237 have registered, 25 of whom are without diplomas. Of course, the defect existing in section 3 will, in time, correct itself. The Legislature evidently did not intend to make the law retroactive, inasmuch as by so doing it was said that some who had been practicing without diplomas for many years might be deprived of their livelihood; but the evil has been saddled upon the people of the State by this saving clause, and there is no present remedy.

"Another grave and striking defect is found in section 6. This section provides that action shall be brought for violation of this act in the name and for the benefit of the Charity Hospital at New Orleans. But the Board of Administrators of the Charity Hospital have never attempted to prosecute, probably because, it may be, that they do not consider it within their province to do so, and probably because registration is demanded at the office of the State Board of Health; and until very recently no effort has been made on the part of the Board of Health to inform the proper officials of the Hospital of the names of persons practicing in violation of the law, and unless so done there is no way of reaching delinquents. Besides, the Charity Hospital (or any one else for that matter) does not appear to be very desirous of prosecuting, for the law, while providing a penalty, prescribes no method of enforcement. The last line of Sec. 6 reads, 'he shall . . . be subject to criminal prosecution, and be punished in the manner prescribed by law for violations of this act.' Now this would answer very well, and make the law effective were any such prosecution provided for, but, unfortunately, nowhere upon the statutes of Louisiana can any such provision be found, and as a consequence, the law is to this extent inoperative. This is an oversight which the profession of the State, through the State Medical Society, has endeavored to have corrected, but at its last session the Legislature neglected or refused to make any amendments to the existing law or take any action whatever in regard to State Medicine. With a view to making the present law as effective as possible, and to endeavor to obtain a complete registration of physicians in the City of New Orleans, at least, I, as a member of the Committee on Registration of the Board of Health, a short time since, introduced a

resolution, which was unanimously adopted, providing for the enforcement of the act as far as could be done under existing circumstances. Said resolution provided that, under the provision of Sec. 6 of the act, the Board of Health would refuse to accept certificates of any nature whatsoever, or recognise the same as legal, when issued by any physician who had failed to register, or by any person whose name did not appear upon the books as having duly registered, in compliance with the law. (The Board of Health is by law constituted the registrar of births, marriages and deaths, for the city of New Orleans). The effect has been that, since the adoption of this action by the Board, 41 have registered, bringing the total number registered in New Orleans to the figure stated above, 237.

"At the same time the Secretary of the Board of Health was instructed to forward to the Administrators of the Charity Hospital the names of those persons practicing without having registered, with the request that the Attorney of the Hospital be instructed to prosecute by civil action, and attempt to recover the prescribed fine for the benefit of the Hospital. But nothing has as yet been done to this end, nor has any reply to the request been received by the Board of Health. Were the power given to this Board to prosecute, I think that violations of the act would be less numerous, for the amount to be recovered in fines, and the desire to protect the public from unqualified and ignorant practitioners would be an incentive for active measures. Still, taken all in all, the law, as as it now exists is a vast improvement upon our former condition, when there was nothing to deter peripatetic quacks and pretenders from gulling and fleecing a credulous public."

From Dr. G. D. Hersey, Secretary of the Rhode Island Medical Society, we learn that—

"Through the efforts of the Society one much needed reform has been secured, by which the old coroner system has been abolished, and, instead, there has been instituted a system of Medical Examiners. The law went into effect July 1, 1884, and and gives satisfaction."

Dr. E. P. Fraser, Secretary of the State Medical Society of Oregon, expresses the regret that they have no medical legislation whatever, as yet. They have a bill ready to present at the next session of the Legislature, and hope to secure its passage.

The prospects of successful medical legislation in Massachusetts seem much more encouraging, now that the State Medical Society has interested itself actively in the matter, by intrusting it to the hands of a large and influential committee of that body. The effort to induce legislative action last winter failed, as it had previously done, but it is believed that the profession will now enter more earnestly into the prosecution of the work, with better prospects of success.

Dr. Walter Coles, of St. Louis, Missouri, writes as follows:

"The law now in force is not all that might be desired, but was the best that could be secured by way of a start. It has served a good purpose in interesting the more progressive element of the profession in the importance of legal restrictions, etc., and will, undoubtedly, prove an efficient entering wedge to something better and more efficient, in the near future."

Dr. William Elmer, Jr., of Trenton, Corresponding Secretary of the State Medical Society of New Jersey, states that—

"The law works fairly well in this State, although there is no authorized power to prosecute offenders unless by individually assuming the trouble and unpleasantness therefrom resulting."

Dr. P. H. Millard, Secretary of the State Board of Medical Examiners of Minnesota, states that—

"In Minnesota the Supreme Court has very recently affirmed the constitutionality of the Act in all its features. This decision is important, as the Act is similar to those of Illinois, West Virginia and Missouri, and may influence and confirm the action of those States in the case of delinquents or of those answerable to the law. The law in Minnesota is said to be giving general satisfaction."

Dr. J. P. Booth, Secretary of the Medical Society of New Mexico, speaking of the law which was passed in March, 1882, regards it as a good one, so far as it goes, but it does not go far enough.

"By it, those desiring to practice are required to present their diplomas for examination to the Board, or if they have no diplomas, to appear in person before the Board and undergo a satisfactory examination in Anatomy, Chemistry, Physiology,

Surgery, Materia Medica, and Therapeutics and Obstetrics. The Practice of Medicine is not included. The Board consists of three regulars, two homœpaths and two eclectics. The law paradoxically prescribes that this body, in its rulings and actions, shall be governed by the Code of Ethics of the American Medical Association. It is the aim of the Southern New Mexico Medical Association, of which I have the honor to be Secretary, to amend the law whenever it is possible to do so. Two years must elapse, however, before much can be done, as the present Legislature at its last session passed a law to retain their seats until 1886."

Dr. J. A. Dibrell, Jr., Secretary of the State Board of Health of Arkansas, does not speak in any terms of enthusiasm of the condition of medical legislation in that State. He states that—

"The present Act is by no means satisfactory. The medical profession of Arkansas, for a number of years, made efforts to secure the passage of a bill to regulate the practice of medicine. Such efforts were always defeated by the influence brought to bear by quacks upon the members of the legislature. The bill, or act, now in force was passed in 1881, and it was thought it would be better than none at all, and that is about all that can be said in its favor."

Dr. M. W. Russell, Secretary of the New Hampshire State Medical Society, writes that the law of that State works very well, with but little friction, and gives general satisfaction.

Dr. Charles D. Smith, Secretary of the Maine Medical Association, states that efforts will doubtless be made by a committee of the State Medical Society to secure a law establishing a State Board of Health and Registration, at its next session.

Dr. J. S. Richmond, Secretary of the Vermont State Medical Society, writes as follows:

"In 1876 a law was passed requiring practitioners of medicine to obtain a license of a Board of three Censors appointed by our State Society, or of a Board of Censors appointed by Chartered County Societies. In 1878 some *tinkering* was added. In 1880 our Society, not liking the law, did not appoint censors, intending to treat the law as a dead letter. Last June the law was brought before our semi-annual meeting. We found that the old Board of Censors, by the law, held their office until others were chosen. I have supplied the Board with blanks, and the profession very generally have a license. We anticipate that a State Board of Health, measures to enable us to control disease, etc., will come before our Legislature, which meets October 1, 1884."

Dr. W. G. Brownson, of New Canaan, Connecticut, writes that, since our last Annual Report to the Academy—

"An attempt was made, with the view of suppressing irregular traveling and advertising quacks, but it was defeated in the Legislature. A bill making it a duty to label all patent and proprietary medicine, was also defeated."

Dr. George W. Cox, Secretary of the State Board of Medical Examiners of Colorado, expresses the belief that—

"The State Board of Health will endeavor to have more stringent laws passed at the next meeting of the Legislature."

Dr. W. J. Burt, Secretary of the Texas State Medical Association, writes to say that—

"The present law is not satisfactory, and the State Medical Association has drafted a bill which will be presented to the next Legislature, in January, 1885."

Dr. Hector Galloway, Secretary of the Dakota Medical Society, states that—

"An effort was made by our local Society (Cass County Medical) to obtain from the last Legislature an Act similar to that of Pennsylvania, requiring registration, etc., but the consideration of it was not reached before the Legislature adjourned. An effort will probably be made next winter to have the matter taken up and considered."

Dr. J. T. Reeve, Secretary of the Wisconsin State Board of Health, writes as follows:

"No change has been made in the laws which regulate the practice of medicine in this State since the date of the last meeting, except that a section of a new law requires medical men to report contagious diseases occurring in their practice. I am not aware of any movement looking to a change in the laws regulating the practice. There is, however, a growing interest in this subject, and an increasing belief that there ought to be greater restrictions upon the practice of medicine."

Dr. William Marshall, of Milford, Delaware, states that—

"The law of Delaware, now on the statute book, regulating the Practice of Medicine, is generally regarded."

The same remark may be made in regard to the law of California.

On the other hand, Dr. James A. Gray, of Atlanta, writes to say that—

"The law in force in Georgia is very unsatisfactory to a large number of the best physicians, and yet there seems to be little hope that anything better will be enacted in the near future."

Dr. E. S. Elder, Secretary of the Indiana State Board of Health, thinks it probable that—

"An effort will be made to pass a medical law at the next session of the Legislature, in 1885. At present there is no law on the subject; simply a section of the State Board of Health law requires that physicians shall register their names and post-office address with the County Clerk."

Dr. John Forrest, Corresponding Secretary of the State Medical Society of South Carolina, writes as follows:

"The only law on the subject of Medical Practice which I know to be enforced in this State is a derogatory and contemptible enactment, which permits the municipal authorities to mulct us every January by an exorbitant tax called a license, notwithstanding that we have already been licensed by the State through its chartered institution, the Medical College. This relic of barbarism, I regret to say, is still in force, but I am not aware of any other regulation being strictly observed."

Dr. G. A. Collamer, Secretary of the Ohio State Medical Society, makes the following statement:

"No legislation in reference to medical affairs in Ohio has been completed since September, 1883, nor for many years previous. The only law on the statute books which professes to demand any requirements was passed some fifteen years ago. That law required that doctors should have a diploma; but practitioners of ten years' standing were exempted, and those of less than that time were given five years to obtain a diploma. Efforts have been made here to enforce this law, but it has been found impossible to prove before a court that the accused did *not* have a diploma, the legal assumption being that he did; so the law has proved useless, and all manner of quacks flourish on our soil. A bill was introduced into the Legislature last winter, the design of which was to establish a State Board of Medical Examiners, whose license should be required before engaging in practice. It failed to pass and is now pending. The State Medical Society, at its last meeting, in June, recommended the passing of a bill also for a Board of Examiners, and appointed a special committee to assist in its passage through the Legislature.

"There is practically no legislative restriction on the practice of medicine in the State of Ohio. Any one can and does practice medicine here."

Dr. James W. Holland, of Louisville, Kentucky, states that—

"The law on the statute books in 1883 is still in force. In all but two or three out of a hundred counties it is a dead letter. The State Board of Health made an attempt to get a better law through last winter; it was defeated by prejudice excited by some Louisville medical schools. They will try again at the next Legislature, two years hence."

Dr. R. Lowry Sibbet, of Carlisle, Pennsylvania, writes as follows in regard to the practical working of the "Act to Provide for the Registration of all Practitioners of Medicine and Surgery" in Pennsylvania—

"I would say that the law is generally respected, and that no one, so far as I can learn, attempts to practice without registration. The prothonotary is interested to the extent of one dollar for each practitioner, and the practitioner is liable to a fine of one hundred dollars if he fails to register. These facts make the law self-acting. During the first year, 5654 graduates had registered, representing 173 medical schools, and 838 non-graduates registered (See Reports of Committee on Medical Legislation, in the Transaction of the State Medical Society for 1882 and 1883). The latter class must necessarily diminish in numbers, as no one is permitted to register who was not engaged in practice in our commonwealth in 1871. It is conceded, however, that the supervision of registration is a necessity in order to secure higher attainments, and to prevent false registration, and that this can be done most efficiently by a State Board of Health. The Committee on Medical Legislation asked to be dismissed in 1883, which was agreed to, and the State Board

of Health Committee was continued. We hope that the legislation desired and so much needed will be secured in a few months."

The Committee cannot close this Report without emphasizing the fact, to which illusion was made in their Report of last year, of their great indebtedness to the efficient and indefatigable Secretary of the Illinois State Board of Health, Dr. John H Rauch, for the recent valuable Report of that body, in which the whole subject of medical legislation in the United States and Canada is presented in all its details, for reference. Each act is given in full, exactly as adopted in each State, with all the recent changes in such legislation and the work of all committees engaged in duties similar to that devolving upon this Committee of the American Academy of Medicine is, therefore correspondingly lightened.

In this sketch, given as concisely as possible, of the present attitude of the States and Territories in regard to the restriction of medical practice, your committee believe that there is much to encourage friends of humanity and those most active in the promotion of public health; for although the past year has witnessed but one addition to the list of States willing or anxious to adopt measures for the protection of the public from unlicensed and unqualified practitioners, the most reliable acts already passed are generally operative, and in course of satisfactory execution. Time and the good example set by these States will undoubtedly have their influence in modifying the ill-advised and deficient legislation of other States. Correspondence with medical men in Canada has failed to elicit any novel information in relation to the restrictions of medical practice in that country, its laws being regarded as efficient, and probably not requiring any special modifications.

The U. S. Consul at Rome reports that from the beginning of the Cholera Epidemic in Italy, the latter part of July, to its close, there occurred 21,246 cases of cholera, and 11,072 deaths. Of these 12,402 cases and 6,629 deaths occurred in Naples alone. Quarantine has been abolished on the Italian borders, except in Sicily and Sardinia, where a quarantine of ten days is still maintained against the mainland.

Society Reports.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD DEC. 11TH, 1884.

(*Specially Reported for the Md. Med. Journal.*)

The President, DR. SHAKESPEARE, in the Chair.

THREE CASES OF TUBERCULOSIS.

Presented by *Dr. Edward T. Bruen.*—The following cases I desire to submit to this Society because they have seemed to me valuable, as showing grounds for the belief in the non-specific inflammatory character of some tubercular lesions.

CASE I.—Cassie C., æt. 18 years, was admitted to the medical wards of the Philadelphia Hospital, June, 1884. She was the type of a strong, healthy Irish girl, and until a short time previous to her admission had never been ill in her life. When admitted she was suffering from secondary syphilis and gonorrhœa, the primary syphilitic lesion having occurred three months previous. She was put on the usual specific treatment and seemed to be doing very well until about the 20th of July, when she began to complain of abdominal pain in the right inguinal region, and a vaginal examination showed a purulent discharge exuding from the mouth of the uterus. Upon dilatation of the os with sponge tents an abundant purulent discharge followed; but after transitory improvement an abcess formed in the cellular tissue of the vaginal wall, which finally ruptured, and after discharging freely closed. After a period during which there seemed gradual improvement, she again commenced to complain of abdominal pain and was transferred to the medical ward in October, from which time health progressively declined, great emaciation occurred and she died Nov. 26th.

Autopsy.— Thorax : — Lungs.— Pleuræ were normal, presenting neither effusion nor adhesions. Lungs were extensively hepatized and œdematous, presenting marked signs of croupous pneumonia.

Heart.—Pericardium was normal. The heart itself showed no valvular lesions. The cardiac tissue, however, was pale and atrophied. There was a large ante-mortem clot both in right and left sides of the heart.

Abdomen.—There was no peritoneal effusion. The omentum, as well as the whole peritoneal surface, was studded with minute nodules of a tuberculous nature. There were adhesions between all the viscera. Catarrhal changes were present throughout the intestines.

Liver.—There was extensive peri-hepatitis; the connective tissue was everywhere covered with minute tuberculous nodules. The parenchyma of the liver was granular and rather anæmic, but no tubercles were visible microscopically.

Spleen.—This organ was slightly enlarged but of normal consistence. There was slight peri-splenitis, and numerous tuberculous nodes throughout the whole splenic substance. Kidneys were slightly above normal in size. Their surface was smooth, but, as well as the parenchyma, presented whitish yellow spots alternating with congested points. There were also lesions indicating parenchymatous nephritis.

Pelvis.—There was a prominent abscess in the psoas muscle of the right side. The opening of the abscess revealed a large amount of pus. There were lesions of purulent endometritis as well as vaginitis. The brain, with the exception of an excess of fluid in the fourth ventricle, was normal. Cause of death tubercular peritonitis.

Case II.—A male patient, aged 40, admitted to the medical wards of the Philadelphia Hospital suffering with chronic parenchymatous nephritis. This disease was complicated by pleural effusion on the right side. Under treatment this effusion was absorbed, but within two months he developed symptoms of peritonitis, and died of this complication.

Autopsy.—Kidneys revealed the changes of chronic parenchymatous nephritis.

Lungs.—Structure normal. The visceral and costal pleuræ on left side adherent. Examination of the abdominal cavity reduplicated the appearance of the previously related case, in so far as the peritoneal surfaces were concerned, and also the condition of the spleen and intestines.

The inferior surface of the diaphragm was more thickly studded than elsewhere with minute nodules of tuberculous nature.

The suggestion of peritoneal infection through transference of material from the remains of the pleural inflammation seemed the most natural inference, especially when we recollect the free inoculation of the peritoneal and diaphragmatic lymphatic system with the pleural lymphatic channels.

Case III.—Edward C., æt. 50. *Autopsy.*—External Appearances.—Middle sized, much emaciated man; subcutaneous adipose tissue wasted.

Thorax.—The lungs were somewhat swollen from hypostatic congestion. On section both lungs showed a pronounced tubercular broncho-pneumonia. The left lobe was riddled throughout with tubercles,and pnuemonic raceme-shaped foci, but no cheesy foci nor cavities. The right lung was similarly affected, but in a higher degree and showed a cavity in the upper lobe near apex, which communicated with several smaller cavities around it. There was also a scar at apex of right lung indicating an old healed cavity. The bronchial glands were all enlarged and somewhat cheesy.

Heart.—Was comparatively small in dimensions. Pericardium normal. The heart muscles, valves and orifices normal. Larges ante-mortem clot on right side. The mediastinal glands enlarged, and some of them calcified.In the mediastinal glands and encapsulated in the connective tissue on the right side was found a minnie ball (rifle); no injury to the lungs could be discovered, but the connective tissue in the mediastinum in this locality showed the scar tissue riddied by tubercles. Subsequent examination showed that the ball from the rifle (ball received 22 years ago) had entered at a point an inch and a half within the right nipple, slightly above the mammary line, and must have passed through the right lung to reach locality where found, although no scar could be discovered in the lung.

Abdomen.—Peritoneum normal. The lymphatic glands somewhat enlarged. The liver was of normal size, in second stage of fatty infiltration. Kidneys and supra-renal bodies normal.

Spleen atrophied. Rest of organs normal. It is a reasonable hypothesis that the phthisis in this case had obtained a traumatic origin.

In conclusion, it would appear to the writer that the mass of observations already made and constantly increasing demonstrate beyond question the very constant presence of a peculiar organism in tuberculous process; yet, at the same time, there are certain nodular and cheesy processes undoubtedly tuberculous, in which the organism has not been found. Probably some

of these failures are traceable to imperfection in the method of searching for it, but other cases are inexplicable on this ground. It seems probable that certain local inflammations, or irritants can give rise to tubercular and cheesy tubercular non-specific (in the sense of organisms present) products quite local in character. When these lesions are diffused throughout the body their diffusion is evidently governed by lymphatic circulation which may permit transference of irritant material from the site of the primary inflammation to a new situation.

The bacterium on the contrary is capable of developing a tubercular specific process over the entire system, and researches seem to warrant us in designating this process as a specific tuberculosis.

Thus considered, the bacillus tuberculosis becomes one of the causes of tubercular inflammation. The question of the frequence of its operation is still unsettled, but side by side is possible the non-specific (in sense of the presence and etiological relation of organism) inflammatory nodules which is subject to similar degenerative processes as the so-called specific nodule. Were this Society a clinical body very weighty clinical evidence, it seems to the writer, could be adduced to defend the above statement.

DISCUSSION.

Dr. Shakespeare said that no examination for the tubercle bacillus had been made. He thought that neither of the three cases as they stand, could, with our present knowledge, be considered to be of such undoubted significance as to warrant the claim that they are representative of a class of tuberculosis in man without the presence of the tubercle bacillus. In the minnie-ball case, too much time had elapsed, viz., twenty years, in view of the fact that experimental investigation seems to show that only a short time—at the shortest two weeks—is required for the development of artificial or inoculated tuberculosis. He thought, therefore, that we were hardly justified by such testimony as presented by these three cases, in assuming in the face of the positive evidence of experiments, that there was a tuberculosis without bacilli. With regard to one of the abdominal cases, it may be remarked that there are cases on record where abdominal serous tuberculosis seems to have arisen by the passage of the virus along the fallopian tubes.

Dr. Formad said that he plainly recalled the minnie-ball case, and that examinations of the sputum, during life, and of scrapings of the lung, post-mortem, failed to reveal bacilli, at least any which gave a typical reaction.

Dr. Bruen desired to say in conclusion that no one was in a position to affirm the positive etiology of tuberculosis; but the two cases of abdominal tuberculosis might inferentially be considered instances of non-specific inflammatory tubercular disease, rather than specific.

HYPERTROPHY OF PROSTATE GLAND; CHRONIC CYSTITIS; CYSTIC AND CIRRHOTIC KIDNEYS. DEATH FROM EXHAUSTION.

Presented by *Dr. J. H. Musser.*—C., æt. 60, minister, under the care of Dr. R. M. Girvin. In good health until 1879, when he began to suffer from pain at the neck of the bladder, with frequent micturition, which soon developed into a cystitis. From this time until his death he suffered from constant pain and irritable bladder, with recurring attacks of cystitis. During the attacks of cystitis the urine presented the usual changes of that disease. Two or three times in the course of the disease he passed a little blood. After a years illness catherization, which had to be performed occasionally, became the rule. On account of the pain morphia had to be given in increasing doses until death. The combined influence of his depressing disease, and the morphia habit, rendered Mr. C. unfit for any duties, the nutritive processes failed, and death resulted February, 1884, from exhaustion.

On examination, eighteen hours after death, rigor mortis was well marked, the body was emaciated, the face sallow in appearance; abdomen alone examined. The stomach and intestines presented the usual appearances found when death results from long continued exhaustion. The kidneys were granular in appearance, very hard; the capsules were adherent, the cortical portions contracted. On the surface numerous small cysts were seen in both organs. They were not weighed, but both were atrophied. The liver was fatty; the lumbar lymphatic and mesenteric glands normal. The bladder was small and its walls much thickened

and somewhat ribbed. At the base the mucous membrane was congested but not ulcerated. The prostate was much enlarged, very hard and encroached on the cavity of the bladder.

The interest of the case centered in the microscopical examination of the prostate; for, ten years previous to the present illness, Dr. G. removed a small tumor, probably a fibroid, from the patient's head; while shortly afterwards a persistent tendency to ulceration on the tumor, recurring for a year, was only checked by frequent applications of nitrate of silver. Then there was a marked tendency to carcinoma in his family; with other evidences, that of his sister's history, she having had mammary carcinoma. Sections of the tumor showed the histological appearances of a chronic inflammation with hypertrophy of the gland.

TUMOR OF BLADDER (ENLARGED THIRD LOBE OF THE PROSTATE GLAND), RETENTION OF URINE, FALSE PASSAGE MADE BY SOFT CATHETER, SEPTIC FEVER, DEATH FROM EXHAUSTION.

Presented by *Dr. J. H. Musser.*—J. M., æt. 84. In early life unusually robust and active in his calling—gardener. The latter ten years of his life has been sedentary, chiefly on account of a large leg ulcer and varicose veins. Moderately using alcoholic stimulants, he smoked to excess. Never confined to bed from any illness. Family history good.

Six months previous to coming under my care he experienced difficulty in micturition. This gradually increased until finally the effort to relieve his bladder had to be continued one-half hour before being successful. I saw him the fifth day of complete retention of urine. After some difficulty I passed a soft catheter and drew off about one half the contents of the bladder, this organ having reached to the umbilicus. The operation had to be repeated twice a day until his death. It was noticed that the instrument twisted in its course. For one week chills and irregular fever followed the passage of the catheter. Death took place from exhaustion three weeks after the retention took place. It may be noted that in the rectum, by the finger, a growth was discovered corresponding to the prostate gland. There never was any vesical hemorrhage.

Autopsy—Heart, liver, kidneys and bladder alone examined. The rigor mortis was marked, the body not emaciated. The man was very large, and yet his heart was unusually small, especially when the condition of the kidneys are taken into consideration. They were cystic and the seat of interstitial inflammation. Neither organ was weighed, and they were not allowed to be removed. The liver was fatty. The bladder was removed for examination. It was much enlarged, its walls thin and markedly "ribbed;" its mucous membrane not inflamed. In the trigone corresponding to the middle lobe of the prostate, a tumor, soft, readily titillating, with a flat base and pointed apex was seen. It grew directly into the mouth of the urethra completely occluding it. It was very red but not ulcerated. The catheter had passed through the floor of the urethra one-half inch from the vesical terminus, and emerged in the bladder to the right of the base of the tumor. I purposely have not made any sections as I desired to show the growth in its entirety. I suggest its reference to the committee on morbid growths. I may say that on account of the above mentioned physical characters the tumor appeared to me to be a papilloma.

Report of the Committee on Morbid Growths on Dr. Musser's specimen of tumor of the bladder, presented at the meeting of November 13th, 1884. (The notes of the cases having been mislaid, they were read at the meeting of December 11th, 1884.)

"Your committee reports that this specimen is a Hypertrophy of the third lobe of the Prostate Gland."

SARCOMA OF SKIN; SECONDARY SARCOMA OF LIVER; OVARIAN TUMOR. RAPID DEVELOPMENT OF HEPATIC SYMPTOMS. DEATH FROM EXHAUSTION.

K. T., female, white, single, æt. 28, housekeeper, good habits. Family history good. No previous illness. Under care of Dr. Ludlow in Presbyterian Hospital. Health good until five weeks ago. She then experienced an attack of abdominal pain, which occurred suddenly, and, although relieved, continued with more or less severity until death. She noticed one week after this accident a swelling below the ribs of the right side. During the two years previous to the development of these symp-

toms she had to micturate frequently, but since then the urinary symptoms subsided.

On admission, November 22nd, 1883, the abdomen was distended from ascites, and a tumor was noted in the epigastrium and right hypochondrium. The liver dulness extended from much below the nipple to six inches below the ribs in the upper line. By palpation its outline could be defined at the umbilicus, and, on the right side, at the crest of the ilium. The surface of the liver appeared smooth, its border even; tenderness was marked. In addition œdema of the legs was very marked, the body was much emaciated, the countenance of a dusky hue, the conjunctiva slightly tinged with bile pigment.

Further, the murmur of mitral regurgitation was heard over the heart, the breathing was labored and the lungs œdematous. The temperature was normal.

Appetite poor, tongue heavily coated, bowels constipated; one passage showed the fæces dark and hard; urine albuminous, sp. gr. 1010, light in color. Death two days after admission from exhaustion and œdema of lungs.

Autopsy, eight hours after death.—Rigor mortis marked; trunk emaciated; abdomen distended; legs œdematous; face dusky and yellow tinged. In section cavity of abdomen filled with bloody serum; lungs œdematous; heart small; left ventricle wall thickened, averaging one-half inch; mitral leaflets thickened and incompetent; spleen enlarged twice its normal size, soft and pulpy; kidneys cirrhotic, but not granular; congested. In the left iliac fossa a cyst found with dark-colored gumous fluid concontents, lobulated and springing from left broad ligament. It was to the liver and a tumor of the groin, however, that I wish to call especial attention:

The liver was not weighed, but was about three times its normal size. Two large, round, yellow-white, umbilicated masses were seen on the surface, corresponding to the nipple line. On section they were soft, cream-colored, vascular at the periphery, the size of small oranges. Smaller similar masses were found scattered throughout the liver. The tissue of the liver between the masses was normal. The gall bladder contained normal bile; the large bile ducts were free and healthy.

In the right groin two flat wart-like growths, hard and pale, the size of hickory nuts were seen, firmly connected with the sub-cutaneous tissue and inguinal glands; rather than watery in appearance, they looked not unlike a mulberry imbedded in the skin, save in color. The glands of the corresponding groin were enlarged and matted together by a local inflammatory process.

Microscopical sections of the tumor of the skin and of the growths in the liver showed the appearance of an alveolar sarcoma; those of the skin developing from the adjacent connective tissue, and being the primary growth in all probability. These sections were made by my student, Mr. Weaver, and the character of them confirmed by Dr. Formad.

I remark that the tumor of the skin was probably the primary growth, for on examining the cyst of broad ligament, the left ovary could not be well defined, but in its place a nodule was seen which might have been a sarcomatous ovary. The tissues were too much destroyed for microscopical examination.

DISCUSSION.

Dr. Davis considered that the point of origin was the most important question. He doubted whether it had really started from the skin. Most of the cases which he had seen had started from the connective tissue, that is the deep fascia. The fact of the ready enucleation of Dr. Musser's tumor would go to prove that there was a pedicle deeper down, which might have been found if sought for.

Dr. Guy Hinsdale presented a specimen of

COMPOUND FRACTURE OF THE LEG AND FOOT. AMPUTATION AFTER ONE YEAR. RECOVERY.

Wm. M., æt. 35, while at work in a mine was severely injured by a large quantity of coal, which fell upon him, crushing his right ankle. The external and internal malleoli were broken. and the soft tissues considerably lacerated. The patient was then transported to the Pennsylvania Hospital, Philadelphia, and placed under the care of Dr. R. J. Levis, and at the patient's urgent request conservative treatment was adopted. Drainage was provided for by means of large incisions; sinuses formed, the joint became anchylosed, and dead bone was felt in every direction. After remain-

ing eleven months in the Hospital he was discharged. He was admitted to the Episcopal Hospital in Nov., 1882. Sinuses extended toward the joint and behind the calcaneum. The lower extremities of the tibia and fibula were necrosed. Several attacks of erysipelas delayed operative treatment to which the patient had consented.

Jan. 11, 1883. *Dr. C. B. Nancrede* amputated the leg at the upper third, making use of a short anterior and long posterior flap, cat-gut ligatures and silver sutures. The operation was done with full antiseptic precautions. The spray was from a solution of acetate of alumina equal to 2½ per cent. of saturation. The instruments were kept in a 2½ per cent. carbolic acid solution. The wound was dressed with lint saturated with the acetate of alumina solution; over that was placed carbolized gauze; then the Mackintosh, which was secured by a rubber band above and by strips of plaster. Four dressings were made under the spray, and boracic acid ointment was applied over the stump on the third and fourth dressings, which were about three days apart. In four weeks the patient was up in a chair. The most gratifying feature of the case was that at no time after the operation did the temperature rise above 98.5° F.

The specimen has been macerated and shows the original fractures with complete anchylosis of the joint. The fragment of the internal malleolus has disappeared. Above its site the bone is rough and carious. A broad osteophyte is situated on the inner side of the lower end of the bone. The tibia is firmly united to the astragalus and also to the fibula. The latter bone was fractured one and a half inches from its lower extremity. The fragments are united by a small band of bone about one-fifth the thickness of the shaft. The fragments abut firmly against the tibia, the lower fragment resting under its articular surface, and being co-ossified with it. The upper fragment is also firmly united to the tibia. The scaphoid, cuboid, calcaneum and astragalus are thoroughly co-ossified. Their surfaces especially on the outer and posterior sides are rough.

DISCUSSION.

Dr. Davis said that the case had already been under treatment for two weeks before admission to the Pennsylvania Hospital. It had been merely dressed with resin cerate, and the parts had become much swollen, with large quantities of pus exuding. After consultation, Dr. Levis had attempted conservative treatment.

Dr. Nancrede explained his reasons for so severe a procedure as amputation, which, briefly, were the utter uselessness—nay, worse, excessive painfulness—of the member when used, and the frequently recurring attacks of erysipelas after even the slightest probing or use. In view of this latter fact the admirable course pursued by the case under antiseptic treatment was eminently suggestive.

The following report was read by the Chairman of the Committee:

Report of the Committee on Morbid Growths on Dr. Fisher's Specimen of Peritoneal New Growths, presented at the meeting of Nov. 13th, 1884. "Your Committee reports that this specimen is one of peritoneal carcinoma, primary in the pancreas and thence spreading to the omentum and expressing itself as a miliary carcinosis.

Dr. J. H. Musser presented a specimen of ULCERATIVE ENDOCARDITIS, the notes of which will be shortly published.

Dr. Shakespeare presented several microscopic slides of the cholera bacilli, recently sent him by Dr. Koch, remarks upon which will be published in the future.

Dr. A. S. Roberts presented two specimens of HIP-JOINT DISEASE, the notes of which are reserved for future publication.

A CASE OF LODGMENT OF A BREECH-PIN IN THE BRAIN; RECOVERY.—Dr. G. W. H. Kemper, of Muncie, Indiana, reports in the January number of *The American Journal of the Medical Sciences* a very instructive case in which a lad received a compound fracture of the frontal bone, immediately above the right frontal sinus, by a bursting gun. The breech-pin was found imbedded in the brain, at a distance of one-half inch, and was withdrawn by the aid of dressing-forceps. No untoward symptoms were developed until the evening of the fourth day, when a convulsion ensued because of pent-up pus, and after the removal of the cause no further trouble followed. The lesson to be derived from the study of the case is the necessity of maintaining free drainage, thus preventing an abscess from extending into the brain and becoming fatal.

Hospital Report.

THE PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL.

ANNUAL REPORT OF THE SURGEON-IN-CHARGE FOR THE YEAR 1884. BY J. J. CHISOLM, M. D.

The opening of the new hospital building for the reception of patients marks a new era in the history of the Presbyterian Eye, Ear and Throat Charity Hospital of Baltimore City, and is a cause for congratulation by all who take interest in hospital work. Through the aid of Presbyterians, we have now in Baltimore one of the largest, finest and best furnished special hospitals in the United States, and we are prepared to take a conspicuous part in the charity work of caring for the sick. Our Free Dispensary and free beds are for the use of any person suffering from eye, ear or throat diseases, who is too poor to secure otherwise the professional services of skilled physicians.

We are truthfully told that to give money to the poor who ask alms is not always a good act, and that true charity consists in helping the needy to take care of themselves. From this view of extending benefits to those poor persons who appeal to our sympathies hospitals stand preeminently conspicuous as true charity organizations. These institutions are the least abused of all charities because they offer aid to a class of poor persons whose bodily infirmities cannot be concealed, and who only ask to have their diseases cured so that they can by manual labor procure food for themselves and for those who are dependent upon them for support. The annoyance caused by diseases of the eye, ear or throat to the working classes are as serious in results to them as are the diseases of the arms and legs. Either put a stop to daily labor and threatens starvation to the majority of the world who live from hand to mouth, laying up no store for sick days. In aiding such invalids to get well and resume their occupations good work is being done every day at the Presbyterian Eye, Ear and Throat Charity Hospital, and the thousands from our laboring population who seek its aid every year bless those who have extended it to them.

From May to November, six months of the past year, the ward work of the hospital was stopped, and the dispensary work was very materially interferred with by the alteration, additions and general repairs which were going on. At one time the building had no roof, and for a long period there was no front wall to the hospital. For many weeks there was not a single room completed in which dispensary work could be comfortably carried on. Yet, with all these drawbacks, the number of persons who were treated in the hospital for 1884 exceeded by 26 the number treated during the entire twelve months of 1883, viz., 4,579 against 4,553. The attendance for the year just closed, notwithstanding the six months of interruption, was 24,141, which, when added to the many who have attended in the previous six years, make the astonishing number of 154,264 persons who have obtained medicines and professional advice under this roof. They represent 23,249 individuals, whose diseases are recorded in the hospital books. During the year just closed 748 operations were performed upon the eye, ear and throat of poor patients, summing up with those of the six previous years 4,884 operations performed in this building. The tabulated statement shows a steady increase in the numbers of applicants from the first year of opening the hospital to the present, 1884 being no exception to this, although for six months the hospital work was seriously interferred with. Now that the large and conspicuous building is completed and equipped with every convenience for the care of the sick, the work for the coming year promises to exceed greatly that of any preceeding year.

Simultaneous with the opening of our new eye hospital comes the great discovery of the local anæsthetic action of the solution of the muriate of cocaine, which prevents all pain in eye operations. Eye surgery is now freed from the terrors of chloroform and is nearly perfect. The world seems to have already found this out; for, although the wards of the new hospital have been opened only six weeks, from Nov. 15th to Dec. 31st, besides a great number of serious eye operations, 30 cases of cataract alone have been successfully operated upon. No such large list of operations for so short a time can be shown in the report of any special hospital in the country.

The new feature of nicely furnished private rooms for the well-to-do classes, who by paying for board, can obtain all the pri-

vacy and all the comforts of the best hotel accommodations, to which is added skilled nursing, will bring the Presbyterian Hospital into repute with the many strangers who come to Baltimore as a medical centre for surgical treatment. Already these private rooms have been in demand, and have proved most comfortable homes for suffering invalids while undergoing operations for the restoration of sight.

Our new Presbyterian Eye, Ear and Throat Hospital has a brilliant career before it.

To Render Oral Suction After Tracheotomy for Diphtheria Harmless.—In view of the fact that Dr. Rabbeth recently died in England from diphtheria contracted by sucking the tracheotomy tube, Dr. John W. Ogle writes to the *Lancet*, November 29, 1884, offering the following suggestion, which seems to have a ring of good sense about it.

He suggests that such suction would be rendered free from any risk, provided that a piece of some very thin, soft, and pliable material, such as extremely delicate cambric or silk (so-called "grenadine" or "gossamer"), three or four inches square, were laid over the windpipe and so adapted as to form a small pouch or sac over the orifice made therein, which should be received into the mouth of the operator before the suction was practiced. The character of the tissue or material would permit of the movements of the lips and tongue appropriate to the act of sucking; and the diphtheritic stuff would be almost as easily drawn into the sac contained in the mouth as if nothing had been interposed between the windpipe-orifice and the cavity of the operator's mouth. It would doubtless be, also, advantageous if the substance forming the sac or pouch into which the diphtheritic material would be sucked were well moistened by some suitable antiseptic liquid, such as a solution of boracic or salicylic acid, or a spirituous solution of thymol or diluted oil of eucalyptus. By such a procedure as the above described the diphtheritic films and fluids aspired into the mouth would not, in any case, come into direct contact with its lining membrane; and in this way danger to the operator would be entirely obviated. —*Med. and Surg. Reporter.*

Editorial.

Lancing the Gums in Infants.—A recent paper on the subject of lancing the gums, read before the Medical Society of London, by Mr. Edward Owen, brought out a very strong sentiment in favor of this operation, and showed that it has by no means lost its hold upon the favor of English physicians or become obsolete among them. One commentator—an F. R. C. S.—writes: "I should have thought no man could be in practice a month without having finally persuaded himself of the value of the gum lancet. Cannot every practitioner look back on countless cases of convulsions—perhaps of hours' duration—cut short instantly, of intense reflex constitutional disturbance, high temperature and general febrile condition, great restlessness, great evident pain and distress, perhaps threatened convulsions, at once subsiding on lancing the gums?" The same writer says that the insufficient use of the lancet will often explain the failure to obtain relief from this measure, the incision failing to completely relieve the tension and free the tooth. He further suggests that dentition is not always a simple physiological process as in children "with the large head" who especially need help, convulsions often accompanying the process in them. Likewise the reflex irritation of the brain which originates in the eruption of a tooth may determine the occurrence of that insidious disease, infantile paralysis. To him "it is incredible if other men's experiences be like mine, that in looking back upon their work they do not accord their chief and most obvious triumphs to the use of the lancet and the gum lancet."

A more conservative view maintained by another writer is that dentition is a purely physiological process "accompanied, it may be, with an abnormal excitability of the nerve centres, which renders the system more susceptible to accidental causes of disease such as cold, shock, improper feeding;" that the gum-lancet may be needful, though rarely; that inflammation of the gum is not a usual association in these cases; that tension of the gum is negatived by the absence of gaping after incision and by the readiness with which the incision heals, and that favorable results—immediate relief of diarrhœa, bronchitis and convulsions—is not of such constant occurrence that it may not be regarded as a *post hoc*, etc.

That the practice of lancing the gums has fallen very much into desuetude is unquestionable. Whether such a fact is capable of justification may well be questioned. In itself a very simple operation and entirely devoid of danger, if there are good grounds for believing that it is even exceptionally beneficial, we are unwise if we withhold from our little patients, in suitable cases, the relief which it may be expected to confer. Now there are the very best authorities, old and recent, who maintain its utility. In the discussion above referred to, for instance, such well known physicians as Drs. Clement Godson, Braxton Hicks, Parramore, Hamilton Cartwright, C. J. Hare, Webb, Duncan, Ewart and Drew, testified strongly in its favor. Such testimony could, we believe, among our readers, be multiplied many fold. As Dr. Hicks remarked, the nervous economy of the child is exceedingly sensitive, and reflex disturbance may be readily set up by the eruption of the teeth. May it not be that most of the opposition to the practice results less from conviction or proof of its inutility than from that tendency to therapeutic nihilism now so prevalent, or perhaps to an unwillingness to resort to instrumental methods especially cutting operations common among a large class of physicians? We should be glad to elicit from our readers an expression of opinion on the subject, and especially from those experienced country physicians who have practised it in so many hundreds if not thousands of cases.

Suggestions Applicable to the Season.—At this season of the year the practitioner of medicine is usually interested in gathering in the results of his past year's labor. It is eminently a time when his thoughts turn from the pursuit of scientific speculations to the every-day affairs of life, which must press with more or less weight upon all who struggle for the necessities of life. Whatever motives may actuate a few scientific devotees, the fact remains that the vast majority of medical men are working and toiling for bread and meat for themselves and for their families. The doctor has necessities just as other people, and he generally works harder than the majority of people to meet these necessities. He has obligations to meet just as other people, and, as a rule, must depend upon his medical work to meet them. If, in addition to his scientific attainments, he possesses a fair allowance of business thrift and enterprise, his obligations are generally met, and the hand of penury presses lightly upon him. Unfortunately, however, a large number of medical practitioners are deficient in those qualities which go so far to make their toils light and their obligations easy. Many physicians are careless in money matters. They are poor collectors, and from this fact are often indifferent creditors. They are frequently too easy in demanding what is due them, and correspondingly careless in meeting their own obligations. In this way they lose a large share of their hard-earned services, and become, in consequence, involved in their responsibilities to others. We have known a physician to mortgage his inheritance, to borrow money from banks and money-lenders, to meet pressing family expenses, rather than enforce collections from patients amply able to discharge their obligations to him. It is easy enough to see the result of such a method as this. A look into the homes and surroundings of the widows and orphans of many deceased medical men is a sufficient commentary upon this system of medical practice. The statement is often made that the profession is over-crowded, and is in great danger of impoverishment from this circumstance. We believe that the true danger is from another direction. It comes rather from the use of faulty methods of conducting practice, from neglect and carelessness in collecting bills for services rendered, from undercutting and underbidding for patronage. The effect of a system of lowering fees, and of careless collections, will affect an entire medical community. One physician can disorganize a whole section of a city, town or country in which he may happen to reside, by adopting methods after this manner. Because a physician is engaged in a peculiar character of public service, is in itself no reason why his business methods should vary widely from those adopted by others who work for the public good. We certainly would not undertake to encourage a purely monetary view of medical work. The physician who sees only in his work a result in dollars and cents, has not the highest conception of his art.

But the physician should not confound his dual relations to the public. He should

not be carried away by a false sentiment on the one hand, or a purely mercenary spirit on the other. There is a just blending of the two, and he should aim to conduct his medical work on a basis that will insure respect, authority and a just compensation for his services as a public servant.

To insure this respect as a doctor (teacher) it is just as necessary that he should be a man of integrity, of scrupulous honesty, and of correct business dealings as that he should possess medical attainments. The public does not always form its estimate of a physician by his skill or knowledge. Indeed his moral and personal qualities may far over-balance his astuteness and learning. The man who seeks public patronage upon his scientific attainments and nothing else, is far less likely to succeed in securing it than the man who relies upon his moral and personal qualities with only a modicum of medical ability. In other words the practitioner of medicine must be possessed of not only skill and learning, but of high moral, social and personal qualities as well, if he would attain the highest position of respect and influence in any community.

Turning now to the purport of our remarks, the season of the year suggests a collection and settlement of accounts; it calls for a few weeks to be given up to business considerations. Let every physician make off his accounts, enforce their collection, and then discharge his business obligations. The surplus should find its way into safe and judicious investments. The inquiry may suggest itself, why venture such advice? We answer, we believe it is needed. Our work as journalists brings us into relations with many physicians. We know how careless and reckless many of them are in money matters. We know that many of them fail to collect what is due them, and many more fail to pay what they owe others. We do not attribute such failures to dishonest principles. On the contrary, we believe that many of these very men would give away their last cent if asked for it. They are generous, but not just. Their faults are the outgrowth of a recklessness and carelessness in matters of business, which if applied to their habits as practitioners of medicine would make them dangerous citizens to any community. Therefore, we say to those who are careless, collect what is due you, square up accounts, and lay aside a surplus for future use.

Shall we Have a Law to Regulate the Practice of Medicine in Maryland?—This is a very pertinent question; we ask our Maryland readers for an answer. In view of the importance of the subject we invite attention to the "Report of Laws Regulating the Practice of Medicine in the United States and Canada," prepared by Drs. Dunglison and Marcy for the last meeting of the American Academy of Medicine, which met in this city in October last, and is now published in full in the present issue of this *Journal*. It will be observed that this movement to protect the interests of the profession by legal restrictions has made considerable progress during the past few years. In a number of the States laws regulating the practice of medicine are not only in force, but since their adoption have had a most beneficial influence upon the status of the profession within their borders. In the State of West Virginia a law regulating the Practice of Medicine and Surgery went into operation in March, 1881. In the language of the Secretary of the State Board of Health, Dr. James E. Reeves, it, "to the present, has been a continued success—a blessing to every citizen of the State, and a strong arm to uphold the dignity of the medical profession within our borders." A similar law has been in force in North Carolina for some years. This law is not thoroughly satisfactory to the profession in that State, and an effort will be made to revise and enlarge it.

During the past year the Legislature of Virginia enacted a law establishing a Board of Medical Examiners and of Registration. This law, in many respects a good one, went into operation on January 1st, 1885. The profession in the State of Pennsylvania will make an effort during the present winter to secure the passage of a law establishing a Board of Examiners and of License in that State. The State of Delaware has now on the statute book a law regulating the practice of medicine, which, we understand is generally regarded. Thus, it appears, that all of the States immediately adjacent to the State of Maryland have laws, already in force, regulating the practice of medicine, or are seeking to secure the passage of such laws. It is pertinent to inquire, what are we doing in Maryland in this respect? We answer, absolutely nothing. We ask whether the profession proposes to remain in this state of inactivity? Is nothing to be done to suppress the in-

crease of quackery which is now pouring into this State? Whilst our sister States have closed their doors against unqualified and ignorant practitioners and pretenders, we are offering them an asylum whilst they continue to fleece and gull a credulous public. Our city is overrun with every species of medical humbuggery; it is a perfect paradise for the peripatetic quack and irregular; it is the home for the manufacture of patent nostrums and specifics, which vaunt their boastful claims and cure-alls on house, sidewalk and bill-post. Our air is filled with these evil influences; even members of our profession have been contaminated by such morbid surroundings. We ask will the profession in Maryland do nothing to correct these influences at work in our midst, which are vitiating both public and professional opinions and conduct? Shall we have a law to regulate the practice of medicine, or shall we continue to go from bad to worse, until quackery and fraud make conquest of our people? If we have exaggerated the importance of this subject we ask some one to discuss it in its true light.

Prospects of a State Board of Health in Pennsylvania.—The *Med. News* rejoices over the prospect of securing for the State of Pennsylvania at last a Board of Health. It points to the fact that twenty-seven States have such organizations, whilst the great States of Ohio and Pennsylvania still remain without them. It is a surprising fact that this should be so and especially in Pennsylvania with its preponderating medical influence. It only points to a want of union in the profession, to a failure to utilize the means for making known our wishes and rights as a profession which the lowest of the trades have been utilizing to their advantage for many years, and it seems to justify the statement of Ashe that our profession is comparatively but a disorganized rabble. We hope that the conference of delegates of the local organizations, which was held at Harrisburg on the 13th, was able to convince the Legislature of the vast importance of their mission and to obtain assurance of the passage of suitable legislation.

A Peculiar Form of Pneumonia.—At a recent meeting of the Medical Society of London, Sir Andrew Clark described a peculiar form of pneumonia which he had recently observed in a gentleman 82 years of age. The consolidation occurred in patches, first in the lower, then in the central, and next in the upper parts of one lung. The disease then passed to the opposite lung, and affected it in a similar manner. With each consolidation the patient was extremely ill. Sir Andrew Clark could give no better description of the condition than "relapsing pneumonia." In the discussion of the case no similar pathological condition had been discovered by any of the speakers, and there seems to be no record of similar cases. The opinion was generally expressed that the probable ætiology of the case was of a septic origin, although no source of contagion could be discovered even after a most careful search. Sir Andrew Clark believed it might be due to that protean malady gout.

Book Notices and Reviews.

The Principles and Practice of Gynecology. By Thomas Addis Emmet, M. D., LL.D., Surgeon to the Woman's Hospital of the State of New York, etc. Third Edition, Thoroughly Revised, with 150 Illustrations. Philadelphia: Henry C. Lea's Son & Co. 1884. Pp. 876.

The first and second editions of Dr. Emmet's book are so familiar to the student of gynecological literature that a lengthy notice of this third edition may, at first sight, seem a labor of supererogation. This statement would certainly hold good if applied to the vast majority of books which reach their third edition. An exception must be made in favor of the work under consideration. Dr. Emmet does not belong to the class of ordinary book-makers, and the fact that he again presents his work to the profession carries with it the promise that it has received a most careful, thorough and conscientious revision. The advance and change of views in gynecology during the past three or four years have been so great that Dr. Emmet has gone though the labor of rewriting this volume; a great deal has been left out and much new matter has been added. A comparison of this edition with previous ones shows everywhere the author's careful work; his minute attention to details; his modification and elaboration of former opinions; his larger

experience and original research; his growth in resources and in the mastery of the science he has done so much to enrich by his labors and studies. In its present form Emmet's Gynecology may be viewed as a new book enlarged and enriched by one of the clearest, most painstaking and conscientious clinical students America has produced. The style and personal characteristics of Dr. Emmet's writings have in no sense been altered. The author's honesty, independence and sincerity of purpose are seen on every page of the book. He speaks for himself; tells what he has seen and observed, and gives a reason for the faith that is in him. A student and observer of Dr. Emmet's cast of mind will necessarily hold views and opinions not wholly in accord with the current thought of the profession. Dr. Emmet is eminently an original investigator with theories in advance of his practice; theories, however, which will develop into important principles of practice under his masterly conception of the adaptability of means to an end. His original conception of the influence of lacerations of the cervix upon pelvic pathology and his operation for the correction of this lesion is a fit illustration of the clearness of his mental vision in gynecic surgery. The acceptance of his views and the practical results of his study and teachings in this operative procedure show that he is a leader in original work of the most trustworthy character. In the edition before us Dr. Emmet has carefully revised the chapters upon laceration of the cervix. He discusses in a masterly way the opinions and objections urged against his operation, and, in our judgment, has placed this subject upon stronger and more impregnable ground than it has hitherto occupied. The work he has done in this direction is established for all time. His facts cannot be controverted. If the principles which he teaches are reduced to practice in the manner in which they are advised no surgical procedure is more clearly indicated than trachelorrhaphy.

Not content with the laurels he has won in devising the operation which bears his name, Dr. Emmet has pushed his investigations into new fields of exploration. This was to be expected of one whose surroundings command a wealth of clinical material for observation and study.

The anatomy of the perinæum, the relation which this body bears to prolapse of the posterior vaginal wall, and the effect of its destruction upon uterine pathology have been fruitful subjects for study and controversy during recent years. Dr. Emmet, as one of the earliest students of this subject, some years ago, devised an operation for the closure of a rupture of this body. This operation is so familar that its practice has been almost universal. It is not, then, a matter for surprise that Dr. Emmet's abandonment of the former method for a new procedure should have drawn forth an animated discussion when the announcement was made before the *American Gynecological Society* several years ago. One of the speakers on that occasion was emphatic in the assertion that Dr. Emmet had "wiped out all his former teaching." Such in effect was the impression conveyed by Dr. Emmet in his new departure; but Dr. Emmet is too frank and earnest an investigator to cling to an opinion or to a practice which experience has shown to be injudicious, ill-advised and faulty. His abandonment of the old and conversion to the new method of closing the perineal body is in keeping with the cardinal traits of his character as a student of nature. In the edition before us the author enters into a complete discussion of the subject; his views are carefully defined and his method faultlessly explained. We believe in this new operation Dr. Emmet has developed an important method, and that it, as now devised, will stand the test of a most critical experiment. It is a method which the reviewer has followed with the most satisfactory and convincing proof of its value.

Dr. Emmet advances another step in original work. It is well-known what a faithful student the author has been of the diseases of the female bladder and urethra. Here he has worked with unflagging patience and perserverence. With that ingenuity born of genius and skilled by practice, Dr. Emmet turns to urethroplasty for still further triumph in operative methods. His button-hole for establishing an artificial urethro-vaginal fistula is a practical contribution of the most important character. Dr. Emmet presents this subject at full length in the edition before us. The chapters on it are worthy of most careful consideration. A doubt may be raised as to the necessity for the employment of the button-hole operation for all of the conditions

named by the author. In his own hands none will, probably, question the efficacy of this measure, but to less experienced practitioners the indications calling for its employment may appear dim and uncertain. It seems to invite a method of relief for conditions which are not likely to be clearly recognized by the average clinical student.

Had we more space at our command there are various novel and practical suggestions presented by Dr. Emmet worthy of lengthy notice and discussion. The author's views on uterine pathology are, in a measure, peculiar to him and, to some extent, at variance with orthodox opinions. Dr. Emmet recognizes under the general term, "pelvic cellulitis," the chief factor in uterine disease. He asserts that pelvic cellulitis is the most common and most important disease with which women are affected. To this undetected condition Dr. Emmet refers the bad results so often complained of in the management of the diseases of women. "A great advance in the treatment of the diseases of women will be made whenever practitioners become so impressed with the significance of cellulitis as to apprehend its existence in every case." For this simple classification of utero-pelvic inflammation Dr. Emmet has one universal method of treatment. Hot water he holds to be the *sine qua non* in all uterine disease.

In closing our hasty notice of this book we cannot forbear from giving expression to a deep and sincere appreciation of Dr. Emmet's work, and from voicing the opinion that its value as an authority and guide in the subjects of which it treats is unequaled by any work in any language. T. A. A.

Miscellany.

Use and Abuse of Obstetric Forceps.—Tears of perinæum will occur whether the physician use forceps or not, but in the majority of cases they come from the use of forceps or rather abuse of them. When the proper time comes put on the forceps and boldly bring down the head, but when it begins to bulge the perinæum take them off. You will thus rarely have a bad tear, and if you do will not get the blame for it. It is a very rare thing for me to end a labor with the forceps on. When the perinæum begins to bulge, I support the handles to see whether the pains are strong enough to end the labor; if so, I remove the forceps. There is such an abuse of this instrument that I sometimes think that Baudeloque was right in saying that it had done more harm than good. It requires great skill and judgment to end a labor with forceps. From inexperience or being demoralized by a long and tedious labor a physician is liable to use undue violence and deliver the head too quickly, or to make traction in the wrong direction. I have myself torn the perinæum, and seen many good physicians do the same. Therefore unless there be excellent reason to the contrary the forceps should be taken off when the head reaches the perinæum. Occasionally one blade will catch over an ear, and you cannot get it off, but in the majority of cases it can be removed.—*Prof. Goodell, Clinical Lecture.*

Migraine.—*Dr. Spender*, speaking from personal experience of this disease (*British Med. Jour.*), says that he always felt particularly well the day before an attack; this warned him so that at bedtime he took a mild aperient of aloes and myrrh, and kept off sleep as much as possible, considering a long and deep slumber as most injurious. Starvation is absolutely to be observed, but tea may be taken hot and strong at frequent intervals. With regard to medicines, he lays special stress on prophylaxis. A dose of Indian hemp and quinine taken every night during the intervals of the attacks, gradually alleviates the disease. In several cases hyposulphite of sodium has seemed to do good.

Curability of Insanity.—*Dr. Kirkbride*, late Superintendent of Pennsylvania Hospital for the Insane, (*Report* for 1883) says: Insanity when uncomplicated, properly and promptly treated, and having this treatment duly persevered in, may be regarded as being as curable as most other serious diseases; but its curability mainly depends upon these conditions. Of the class of cases alluded to, it is safe to say that about as many as eighty per cent may be expected to recover. Most of these, restored cases, continue in the enjoyment of perfect mental health, and are as competent to fulfil all their public and social duties as they were before the accession of the disease.

Officers of the Medical and Surgical Society of Baltimore for 1885.—At the annual meeting of this Society, held January 8th, 1885, the following officers were elected for the year:

President.—Dr. A. F. Erich.

First Vice-President.—Dr. Wm. H. Norris.

Second Vice-President.—Dr. James F. McShane.

Treasurer.—Dr. A. T. Shertzer.

Corresponding Secretary.—Dr. C. B. Ziegler.

Recording Secretary.—Dr. C. H. Jones.

Reporting Secretary.—Dr. Geo. H. Rohé.

Committee of Honor.—Drs. C. H. Jones, Wilmer Brinton and S. W. Seldner.

Committee on Lectures and Discussions.—Drs. A. F. Erich, J. W. Chambers and A. Friedenwald.

Executive Committee.—Drs. John Morris, J. S. Lynch and W. N. Hill.

A Correlation Theory of Color-perception.—In the January Number of *The American Journal of the Medical Sciences*, Dr. Charles A. Oliver elaborates a correlation theory of color-perception. He holds that color-perception takes place through each and every optic-nerve filament. It consists in the passive separation of a specific nerve energy equal to the exposed natural color, from a supposed "energy-equivalent" resident in the peripheral nerve tip, by an active chemico-vital process of the impinging natural color vibration upon the sensitized nerve terminal. The separated nerve energy is transmitted to the central terminus of the filament in the cerebral retina, where it is fully evolved into such a condition as to be transferred into an automatic form of perception by an action upon some unknown contiguous perceptive nerve elements; this constitutes the consummation of the nerve energy force into the lowest (and evanscent) form of recognizable color-perception. Finally, it is carried through similar posts and stations, though now of a higher value, as it was whilst pursuing its course inwards as a sensation, until at last it is completely recognized as intelligent color-perception in the higher color centres; these higher color cells being permanent in type, and forming parts and parcels of the higher perceptive cerebral centres. The first moment that the primary portion of this acting (*i. e.* separation) has taken place, there has been left in the peripheral tip of the primarily impinged sensory filament a nerve-energy material equal to the difference between that individual nerve's "energy-equivalent" and the transmitted nerve stimulus. The healthy peripheral nerve tip returns to its "energy-equivalent," or normal nerve power, the moment the specific energy separated by the received natural vibration has been forwarded for transmission and recognition; whilst the transmitting filament and excited cerebral expansion regain their normal condition the moment the energy has passed them. After the consummation of such action, the filament is again ready for any other natural color-vibration.

Case of Dermatitis Herpetiformis Caused by Nervous Shock.—Dr. Louis A. Duhring reports, in the January issue of *The American Journal of the Medical Sciences*, a marked example of what he has described as dermatitis herpetiformis. The history of the case, including the cause of the disease—a violent shock to the nervous system—is both interesting and instructive.

Annual Meeting of Baltimore Medical Association.—The annual meeting of this Association was held at the Eutaw House, Jan. 12th. The following officers were elected for the ensuing year:

President.—J. T. Smith.

Vice-President.—J. E. Gibbons.

Recording and Reporting Secretary.—G. H. Chabot.

Corresponding Secretary.—J. T. King.

Treasurer.—J. L. Ingle.

Ex. Committee.—E. G. Waters, P. C. Williams, G. Lane Taneyhill.

Committee of Honor.—G. H. Rohé, H. F. Hill, H. H. Biedler.

The evening closed with the usual banquet.

Medical Items.

Dr. K. P. Graybill, of Botetourt Co., Va., and Dr. Samuel S. Henley, of West Point, Va., are dead.

Dr. R. C. Brandeis, of New York, a well-known throat specialist, has disappeared, and it is feared that he has committed suicide. He was subject to neuralgia and mental depression.

Honey is suggested as a good vehicle for quinine by the *Lancet*.

Dr. Parvin reports relief of vaginismus from the application of a 4 p. c. solution of cocaine.

The proceeds of the recent Charity Bazar for the Nursery and Child's Hospital of Baltimore were $6,500 net. The money will be used in furnishing the new wing of the hospital.

The following powder is recommended, applied three times daily, for syphilitic condylomata by the *Med. and Surg. Reporter:* calomel, 30 grains; boracic acid, 15 grains; salicylic acid, 5 grains. Under this the condylomata almost visibly dwindle away.

It is announced that the University of Virginia is about to organize a Veterinary Department, and to erect a hospital for the treatment of diseases of animals.

Mr. John P. Morton, the wealthy publisher, of Louisville, Ky., from whose press emanates the *American Practitioner* and *Louisville Medical News*, has erected a building to be called "The Church Home and Infirmary," to be managed by the Episcopal Church for whites of every nation and creed. His donation amounts in value to $112,000.

Mr. Lowndes reports in the *Liverpool Med. and Surg. Journ.* the case of a young girl, aged 14, to whom syphilis had been communicated during criminal assault by a man imbued with the superstition common among the lower orders that sexual intercourse with a virgin is a cure of gonorrhœal and syphilitic diseases.

An entertainment called "La Cholatière" was given in Oratorio Hall, Baltimore, for the Presbyterian Eye, Ear and Throat Charity Hospital, on the 8th. The most prominent Presbyterians of the city took part in it, the waitresses being dressed in the costume of "The Chocolate Girl" of the Dresden gallery. It was, of course, a great success. $1200 were realized.

A Baltimore Cooking School will be opened by a number of subscribers desirous of securing a supply of trained cooks for this community, January 19th. A building has been erected at a cost of $5000, and capable of accommodating a class of seventy-five to one hundred persons. It is said to be the first distinctively cooking school erected in this country.

The *Sanitary Engineer* has ceased to publish the tables of mortality in the cities of the United States, on the ground that Congress will probably rehabilitate the National Board of Health (on the plan recently suggested by health officers) and the Bulletin of the Board will then again assume this suspended duty.

Dr. De Havilland Hall believes that the necessity for using the gum lancet may generally be obviated by the use of bromide of potassium.

The editor of the *Archives of Medicine*, Dr. E. C. Seguin, of New York, announced the discontinuance of that journal with the issue of Dec., 1884.

The late Francis P. Hurd, of Wakefield, Mass., bequeathed $10,000 to the Massachusetts General Hospital.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from Jan. 6, 1885, to Jan. 12, 1885.

Head, Jno. F., Colonel and Surgeon, retired from active service, by operation of law, on Jan. 9, 1885, under provisions of Act of Congress, approved June 30, 1882.

McKee, J. C., Major and Surgeon, ordinary leave of absence still further extended four months on Surgeon's certificate of disability.

Shannon, Wm. C., Captain and Assistant Surgeon, relieved from duty at Ft. Bridger, Wyoming, and assigned as Attending Surgeon, Headquarters Department of the Platte.

Robinson, S. Q., Captain and Assistant Surgeon, assigned to temporary duty at Portland, Oregon, from Dec. 17, 1884.

Wales, P. G., First Lieutenant and Assistant Surgeon, relieved from duty at Vancouver Barracks, W. T., and ordered to return to his proper station, Ft. Cœuer d'Alene, Idaho.

Official List of Changes in the Medical Corps of the U. S. Navy during the week ending January 10, 1885.

Ross, J. W., Surgeon, detached from the "Monongahela," for treatment at Naval Hospital, New York.

Wells, Howard, Passed Assistant Surgeon, detached from Naval Hospital, Philadelphia, Pa., to the "Monongahela."

Original Article.

NOTES ON JEQUIRITY.*

BY HIRAM WOODS, M.D.,

Assistant Surgeon at the Presbyterian Eye and Ear Hospital.

So much has been written upon jequirity since Dr. De Wecker introduced it into ocular therapeutics in 1882, that all are more or less familiar with its properties. My object this evening is to consider some of the objections which have been made to its use, and to lay stress upon three points which, it seems to me, have not been sufficiently emphasized. Before doing so, however, it may be well to state very briefly that jequirity was first introduced for the treatment of "chronic dry trachoma with pannus." Its action on the conjunctiva is the production of a croupous membrane, accompanied by great œdema of the lids, and a thin, watery discharge. The œdema lasts four or five days. The croupous membrane disappears on the fifth or sixth day from the date of its appearance, which is usually twenty-four hours after the application of jequirity. After the subsidence of the inflammation, the conjunctiva is frequently found smooth and the cornea clear. In other cases many granulations and the pannus still persist. The absorption of the granulations goes on for several weeks after the inflammation has been produced, and the cornea slowly clears up.

Of the objections which have been made to jequirity, the two which I wish to review at this time are (1) the corneal complications resulting from its use—such as ulcers, necrosis, etc., and (2) the production of hard cicatrices in the palpebral conjunctiva.

Dr. De Wecker claims that the cornea really runs no risk, provided the case is one of dry, chronic granulations, and the infusion used is not too strong. He insists upon the contra-indication of jequirity and the danger to the cornea when there is any discharge from the eye; because "when there is already a purulent discharge, not the specific jequirity ophthalmia is then produced, but a violent increase of the pre-existent purulent conjunctivitis." (*Archiv. Ophth.*, March, 1884, pp. 109–10). In the same article he quotes the following remark from Von Hippel concerning the cases in which he had produced corneal ulcers: "These without exception were cases of trachoma in which thus far the cornea had remained entirely intact." In the same number of the *Archives* Dr. Emil Gruening gives a tabulated account of twenty cases, in two of which corneal ulceration appeared during the course of the jequirity ophthalmia. Both were cases of "chronic trachoma". In one the cornea was clear, and in the other there was a light pannus above with a clear surface below. The ulcer appeared in the clear part of the cornea. I have seen four eyes affected with corneal ulcers after the use of jequirity. Two of these were in one patient (Case I.) who had trachomatous conjunctivæ with hypertrophied papillæ and a purulent discharge. Both cornea were clear. This case was one of the first I treated, and the mistake then made I should not make again. The rule against the application of jequirity to discharging conjunctivæ, which is so definite now, was not then established. It took a few such unfortunate cases as this to establish it. After the application of the jequrity the purulent ophthalmia became aggravated, central corneal ulcers appeared, and opacities were left. Case II. had chronic trachoma with old ulcerous pannus in the left eye. In the right eye there was chronic trachoma, a very light pannus on the upper periphery of the cornea, and the rest of the cornea clear. The jequirity had no effect on the old ulcer in the left eye, but an ulcer appeared on the clear part of the right cornea some distance from the pannus. The fourth ulcer (Case III.) appeared on the cornea of an eye with chronic trachoma, faint pannus on extreme upper and lower periphery with clear centre. V.$\frac{20}{200}$. No discharge. The ulcer appeared in the clear centre. (See table below.)

Dr. De Wecker states that "Trachoma with the cornea intact greatly resembles chronic purulent conjunctivitis with marked papillary hypertrophy". A mistake in diagnosticating such a case as trachoma calling for jequirity would readily account for the production of corneal complications. The jequirity would only produce an intensified purulent ophthalmia. I do not think, however, that all the reported corneal complications can be justly attributed to a

* Read before the Clinical Society of Maryland, January 16, 1885.

wrong diagnosis. There is certainly something suggestive in the apparent immunity of a pannitic cornea and the comparative peril of a clear one. The vascularity of the former may have a good-deal to do with this. Soelberg Wells states that "in diphtheritic and purulent ophthalmia those eyes are safest in which there exist either vascular ulcers of the cornea or a vascular pannus, for the nutrition of the cornea is carried on by the blood-vessels upon its surface" (p. 159). May not these abnormal blood-vessels serve the same purpose in a severe croupous ophthalmia produced by jequirity?

Many clear corneæ, however, have passed through a jequirity ophthalmia unharmed. Seven such cases are recorded in Dr. Gruening's table of twenty. Prof. Chisolm has told me that he has used jequirity on a number of clear corneæ in his private practice without any bad result. Still there is, unquestionably, necessity for great care if the cornea is clear. The diagnosis of *trachoma* must be certain, and then the drug must be used in weak infusion, and its effect carefully noted before applying it again.

The danger of producing conjunctival cicatrices has been specially brought forward by Dr. Knapp of New York. In the March *Archives of Ophthalmology* (p. 145) he says that he "feared the *white color* which was left on the inner surface of the lids meant that the mucous membrane had been *destroyed* and *replaced* by connective tissue. If we had to take cicatrices into the bargain, the remedy was not superior to the different modes of cauterization and in that case he would prefer to cure trachoma by sulphate of copper more slowly but with less scars." Dr. Gruening also alludes to this danger of scar formation, and gives in the table, from which I have already quoted, three "cures with formation of raised cicatrices." In the June *Archives* (pp. 244–5) Dr. DeWecker takes up this criticism and makes the point that when a *trachomatous conjunctiva* is treated with jequirity, "it is almost impossible to determine how much of the cicatricial tissue is due to the original disease and how much to the remedy." He has "observed hundreds of patients whose *conjunctiva while normal* had been treated with jequirity. If the inflammation is not severe, not the slightest trace of it in the shape of scars remains; if it is *intense* and of *long duration*, the scars are only faint whitish streaks *upon* the conjunctiva of the tarsus." If these scars, then, are only "faint streaks *upon* the conjunctiva," and not the formation of connective tissue *in* the conjunctiva, they are not greatly to be feared. Dr. De Wecker's test of noting the effect of jequirity on a normal conjunctiva is much more reliable than a test can be on a trachomatous one. If the normal conjunctiva escape altogether when the ophthalmia is of moderate intensity, we need not have very much fear of *jequirity* scars. It is rarely necessary to make the inflammation "*intense*", and its "long" (or short) "duration" can be generally regulated by the surgeon. Dr. De Wecker goes still farther and claims for jequirity the power of "stretching and softening the cicatricial tissue already formed." It thus affords relief by removing the "sensation of tenseness and friction even in cases in which the granulations persist." He is certainly correct in this latter statement. Any one who has seen much of jequirity work, will readily recall to mind such cases as he describes: relief from pain and photophobia in spite of the persistence of the granulations.

The three points in the use of jequirity of which I wish to speak are: (1) The slow absorption of granulations after the acute inflammation has subsided. (2) The possible dangers in pushing jequirity in eyes not susceptible to its influence. (3) The bad results which may follow a too hasty attempt to reproduce a jequirity ophthalmia.

The slow absorption of granulations has been noted by several observers. Dr. De Weckers holds that it is several weeks before all the effects of the ophthalmia are brought out. I think the explanation of this may be the "softening and stretching of the cicatricial tissue of the lids," which has already been mentioned. In the use of jequirity for clearing up the cornea, a decided decrease has been observed in the tension of the eye-ball. This decrease in tension Dr. DeWecker attributes to a "temporary loosening of the scleral tissue, favoring filtration and explaining the clearing up of the cornea by its increased nutrition." The decrease in the hardness and tension of the lids which so usually follows the use of jequirity lasts for a long time. I think it not impossible that this relaxation in the scar tissue of the lids may improve their

nutrition, and bring about the absorption of the granulations, in the same way that the loosening of the scleral tissue effects the removal of corneal opacities. The three cases following will serve to show the good results which time can accomplish.

Case IV.—C. D., æt. 34, was treated in Oct. 1883, for chronic trachoma and pannus. Lids thick. Old scars on conjunctiva. In spite of the use of a two per cent. infusion every four hours for several days, and then of a five per cent. infusion, the only result was the production of considerable irritation with finally a thin, watery discharge, and a very faint membrane which disappeared in twenty-four hours. Jequirity had to be discontinued on account of corneal infiltration. The only immediate results were some relief from his photophobia, and decrease in the stiff feeling of his lids. In this condition he left the hospital in December, 1883. In February, 1884, he wrote me a postal from his home in Virginia, stating that his eyes were getting better, he could read large print, and was soon going to work.

Case V.—J. G., æt. 16, treated in December, 1883, for chronic trachoma and pannus of right eye. Couldn't see fingers in front of eye. Lids thickened. Scars on conjunctiva. No membrane from application of a two per cent. infusion of jequirity until it had been applied five times daily for six days. Only result—Patient said he felt "easier." Granulations and pannus not perceptibly benefitted. A second course of jequirity treatment was employed in January. Patient left the hospital in February. My note-book says he "had lots of granulations left; pannus not all gone but clearer." From March, 1884, when his condition was not much changed, I did not see him till Jan. 9, 1885. I was surprised to find the cornea entirely free from pannus, the conjunctiva smooth with the exception of a few minute scars, and V$\frac{20}{200}$.

Case VI.—E. L., æt. 37, an old inmate of the hospital. Had chronic trachoma, pannus, entropion and old corneal scars. Great photophobia. First treatment in Jan., 1884, with a two per cent. jequirity infusion. Relief from photophobia was immediate, but lasted only three weeks. This jequirity treatment was given three times until April, 1884, when a surgical operation was performed for the relief of the entropion. When she left the hospital in April, both conjunctivæ showed many minute granulations, both corneæ were pannitic and marked by scar tissue. Came back in Jan., 1885, for treatment for conjunctivitis. Were no granulations but faint scars on palpebral conjunctiva. No pannus. Old corneal scars the same as ever. No photophobia.

Occasionally we meet with patients whose eyes are not at all susceptible to the influence of jequirity. The first application fails to produce the characteristic ophthalmia. There may be some watery discharge and a little swelling but this is all. The membrane is either not formed at all or else it is very light and disappears in a day or two. This condition is not a jequiritic ophthalmia. Several cases of this kind have been reported, in which the jequirity was pushed with the intention of producing the characteristic inflammation. In some the attempt has been successful, the jequirity eventually producing its own ophthalmia. In others a thick membrane has finally appeared accompanied by a watery discharge, rapidly charging to sero-purulent and then to purulent. In others the membrane hasn't appeared at all, and the eye has only been kept in a state of irritation. In such obstinate cases the utmost care is necessary in using the drug. Case IV, which I have already reported, was one of this class. The strength of the infusion used in his eyes was at first two per cent. and then five per cent. These infusions were applied three and four times daily for ten days. There was some œdema of the lids and a slight watery discharge. Twice during the ten days a thin membrane formed on the conjunctiva, but each time it disappeared in twenty-four hours. On the tenth day the pannitic cornea became suddenly of a deep red color. It looked as though there had been a hemorrhage into the corneal parenchyma. This stopped further attempts with jequirity. Cold compresses and atropia were ordered. A reference to this case will show that the eyes did very well after the patient left the hospital. In the June *Archives of Ophthalmology* Dr. Knapp relates a case which is very instructive. On the patient's admission to the hospital he showed "considerable puffiness of the upper lids, and papillary swelling of the inner surface of both lids of each eye with granular and diffuse hyaline infiltration." The first application of a three per

cent. infusion to the right eye produced "considerable swelling and discharge and thin membranes on lids which disappeared in twenty-four hours." A second application—forty-eight hours after the first—had only "slight effect." A third application—after another lapse of forty-eight hours—was followed by the appearance of thick membranes with a muco-serous discharge which soon became a pyorrhœa and inoculated the left eye. The proper treatment for purulent conjunctivitis cured each eye and left $\frac{20}{20}$V. In this case there was not at any time a true jequiritic, but a violent purulent ophthalmia. Dr. De Wecker claims that this case was one of chronic purulent conjunctivitis from the start, and never should have had jequirity. Whatever the diagnosis, the case certainly gives warning of the necessity for great care in pushing jequirity when the conjunctiva seems to resist its action. These obstinate cases are comparatively rare. When they do occur, it would be well, I think, to stop the jequirity for a time; at least long enough to allow all effects of the first inoculation to pass away before we make another. We do not yet know enough about its action to go very far in the dark.

I have seen two cases which have convinced me that it is dangerous to attempt to produce a second jequirity ophthalmia very soon after the subsidence of a first. In these two cases a purulent ophthalmia developed on the application of a two per cent. infusion. One of these (Case III) had chronic dry trachoma and pannus. Right eye was greatly benefitted by a true jequiritic inflammation. Three weeks later I inoculated the right eye a second time hoping to completely remove some remaining granulations. At the time, the conjunctiva was succulent, and the granulations soft. The application of jequirity was speedily followed by a purulent ophthalmia which inoculated the other eye. Fortunately prompt treatment prevented bad results. The other was case II above. A few granulations persisting in each eye, I inoculated the left ten days after the first inflammation had subsided. The conjunctiva here also was succulent and the granulations soft. The only result in this case was the production of a muco-purulent discharge which was very troublesome, and became purulent three weeks later. This change to a pyorrhœa, however, I am inclined to attribute to the use of a towel belonging to another man in the hospital who, I afterwards learned, was suffering from gonorrhœa.

In the June *Archives* Dr. Knapp relates a sad case in which he lost both eyes. The case was one of chronic dry trachoma with pannus. He produced in the left eye a true but mild jequiritic ophthalmia. It disappeared on the sixth day and left the "conjunctiva succulent." Two days later he again applied jequirity. Obtaining no membrane he waited five days and used it in both eyes. The left conjunctiva was "succulent," the right was dry. The next day a "*muco-serous* discharge, with thin membranes on both upper lids," was noted; also infiltration of *left* cornea. The third day the "whole right cornea was opaque, in the left a central corneal ulcer." From this point a diphtheritic conjunctivitis ran its course and destroyed both eyes. For this deplorable result it seems impossible to find an adequate explanation. The first jequirity inflammation was so very slight and the effects so meagre that a second inoculation seems to have been justifiable. Still the following question may not be amiss: Did not the "succulent conjunctiva" of the left eye, after the first application of jequirity, contra-indicate its farther use? I do not think that a *first* application of jequirity would be made to a "*succulent* conjunctiva." Why, then, should a second be made after a first application has produced succulency on a previously dry one? In this case of Dr. Knapp's the diphtheritic symptoms seem to me to have first appeared in the left eye as manifested by the "corneal infiltration" and "central ulcer."

In regard to the time for a second inoculation with jequirity in case the first does not effect a cure, I think the following rule had better be observed until we know more about jequirity. "*Do not re-inoculate a conjunctiva until it has become dry either by time or treatment.*"

Although I have dwelt entirely upon the dangers of jequirity, I would not be understood as opposing it. The number of cases cured by it are many times the number of those not benefitted or injured by it. There are certain conditions, however, which contra-indicate its use, and which we very imperfectly understand. It is only by clinical experience, with careful study of each disastrous case and each failure, that we can learn the truth.

In conclusion, I append a table giving a summary of 18 cases treated with jequirity. I have only given those cases of which I have complete notes. The first six—which I have marked thus (*)—presented the clinical aspects upon which I have dwelt above. The others presented nothing of special interest beyond what is shown in the table.

Number of Patient.	Age.	Eye affected.	Diagnosis.	Condition of Cornea.	Strength of infusion used	Number of applications needed to produce inflammation.	Number of inflammations induced	Result of treatment.
I*	32	R L	Mixed trachoma with pyorrhœa.	Clear.	2 p.c.	1 See above		Production of corneal ulcers. See above.
II*	36	R L	Chronic trachoma.	L. Ulcerous pannus. R. Clear below.	2 p.c.	4	2 See above.	Granulations reduced. L. cornea cleared. R cornea ulcerated in clear part.
III*	58	R L	Chronic trachoma.	R. Pannus. L. Clear centre.	2 p.c.	9	2 See above.	Granulations reduced. R. pannus cleared. V. $\frac{6}{100}$. L. corneal ulcer. See above.
IV*	34	R L	Chronic trachoma.	R. } Heavy pannus. L. }	2 p.c, 5 p.c.	44 See above	1	Cured. Able to work two months later. See above.
V*	16	R	hr nic trachoma.	Dense pannus.	2 p.c. 5 p.c.	10	2	Cured. V. $\frac{20}{200}$. See above.
VI*	37	R L	Chronic trachoma.	Pannus. Old scars.	2 p.c.	6	4	Cured of granulations. See above.
VII	30	R	Chronic trachoma.	Heavy pannus. Photophobia.	2 p.c.	4	2	Pain relieved. Cured of granulations and pannus. Eye useful.
VIII	42	R	No granulations. Intense photophobia.	Opaque with very light pannus.	2 p.c.	10	4	Pain relieved. Relapses. Four months after last inflammation had had no pain Cornea clearer. V. $\frac{15}{100}$ from nothing.
IX	10	R	No granulations. Symblepharon posterius.	Heavy pannus.	2 p.c.	5	2	Pannus clearer. V. improved from 20 to 14 Jæger.
X	20	R L	Chronic trachoma.	R. Pannus. L. } Lighter pannus. V. $\frac{10}{70}$	2 p.c.	12	1	R. pannus cured V. $\frac{18}{100}$. L. pannus unchanged. Granulations cured.
XI	24	R L	Chronic trachoma.	Pannus. L. Denser.	2 p.c.	8	2	Granulations cured. Cornea cleared up slowly.
XII	13	R L	Smooth conj. Reads 18 Jaeger.	Cloudy from keratitis. No pannus.	2 p.c.	1	1	No improvement by test-types at time. Four months later entered school.
XIII	10	R L	Hereditary syphilitic keratitis.	Opaque Photophobia.	2 p.c.	2	1	No marked clearing of cornea. No photophobia for five months
XIV	16	L	Eye useless on account of photophobia.	Cloudy from old keratitis 3 yrs ago	2 p.c.	1	1	Cornea clearer. No pain during next five months. V now $\frac{10}{100}$.
XV	45	L	Chronic trachoma.	Pannus 16 Photophobia.	2 p.c.	1	3	Pain relieved. Relapse six months later. Again relieved. Granulations persist, but smaller.
XVI	23	R L	Chronic trachoma.	Dense annus.	2 p.c.	See Foot Note.	1	Granulations cured. Six months later V. $\frac{20}{70}$.
XVII	22	R	Mixed trachoma.	Ulcerous pannus. Photophobia.	2 p.c.	2	1	Complete relief from pain. Relapse in three weeks. Granulations improved.
XVIII	15	R L	Chronic trachoma.	Heavy pannus. Photophobia.	2 p.c.	2	3	Granulations improved, but not cured. Both corneæ cleared by first inflammation R. eye relapsed twice. Has V. $\frac{8}{100}$ from nothing.

Note.—I treated Case XVI during the Spring and Summer of 1884 with sulphate of copper. He improved slowly. In August he was sent by Prof. Chisolm to the University Hospital, where he was treated by Dr. Trimble, Assistant Resident Physician, with jequirity. He is now at work.

A CASE OF POSSIBLE BONY UNION AFTER INTRA-CAPSULAR FRACTURE OF THE FEMORAL NECK.*

BY JOHN B. ROBERTS, M.D.,

Surgeon to St. Mary's Hospital, Philadelphia.

Much has been said against the possibility of osseous repair occurring after intracapsular fractures of the neck of the thigh-bone. It is probable that this teaching has induced more than two-thirds of the general medical profession to believe that bony union of such lesions never occurs. Careful investigation of cases and specimens by competent surgical observers has conclusively demonstrated that such belief is erroneous.† Bony union does occur, though not frequently. In my opinion, moreover, its non-occurrence is to some extent due to the violent and unjustifiable manipulation to which injured hips are often subjected by reason of the attendant's ignorant desire to demonstrate crepitus and preternatural mobility. The diagnosis can usually be made with reasonable certainty without the development of these symptoms of fracture. Therefore, it is unnecessary and improper to imperil the future usefulness of the limb merely to arrive at an absolute diagnosis. In cases of doubt it does no harm to treat the case as one of fracture, even if none exist; but violent manipulation, by tearing connecting bands of periosteum or detaching impacted fragments greatly reduces the probability of union.

Union *may* be bony, and the function of the joint perfectly or almost perfectly restored; if not bony, the bond of union may be a very short fibrous one, giving as good functional result as osseous repair. Hence, the surgeon should treat his cases as if he expected a good cure; for it is impossible to say that a given patient is one in which no attempt at union will take place. Non-union of intracapsular fracture of the hip is, it is true, often found. I have in mind now a case where the autopsy showed no attempt at even fibrous union. Let us not expect this, however, as a rule, for we may thus be led to neglect proper therapeutic measures. Specimen No. 1130[15], of the Pennsylvania Hospital Museum, taken from the patient referred to above, between eighteen and nineteen weeks after the injury, is a good illustration of non-union. It was a transverse fracture at the junction of the head and neck of the bone. Specimen No. 1130[20], from the same Museum, on the other hand, is here shown you; it is described in the Museum catalogue as an intracapsular fracture firmly united; and by longitudinal section shows bony union. The specimen belongs to Dr. T. G. Morton, and was removed from a patient, aged 67 years, twelve years after the accident that caused the injury. There is some evidence of impaction near the base of the neck; and it is, perhaps, *possible* that part of the line of fracture extended without the capsule. Of this we have now no definite evidence, as the ligaments were removed in preparing the specimen. This cast of a specimen is from the Mütter Museum of the College of Physicians, and represents an impacted fracture of the femoral neck in which there was *inversion* of the leg. The patient was under the care of Dr. Conklin, of Ohio.

I have made these prefatory remarks to introduce the clinical history of a patient who has now good use of her limb subsequent to an intracapsular fracture, although treatment was abandoned shortly after the receipt of the injury. She has probably a short fibrous union; possibly a true bony one. In either event, however, the result is gratifying; and teaches that such cases should not be looked upon as necessarily hopeless in respect to union.

She is a German, 78 years old, and was admitted to my ward in St. Mary's Hospital on August 30, 1884, after falling from a street-car. The resident surgeon believed there was no fracture at the hip; but on my visit I considered that the position of the limb and the patient's age pointed to intra-capsular fracture of the neck of the femur. On taking hold of the leg and making rotation without violence I felt indistinct crepitation. At once desisting from further manipulation, I ordered permanent extension by weights and lateral support by sandbags, to be the treatment. Within four days, incontinence of urine, the development of a superficial bedsore, and the debilitated condition of the patient showed me that there was danger of the aged woman dying. I accordingly ordered the resident surgeon to discontinue the fracture dressing, so that the patient's buttocks and

* Read before the Philadelphia County Medical Society, November 19 h, 1884.

† See paper by Dr. N. Senn, in Trans. American Surgical Association, vol. i, 1883.

back could be kept clean, and the bedsore properly dressed; telling him that no union of the fracture was likely to occur, and that we must endeavor to save life by tonics, stimulants and food, and the prevention of further bedsores. I gave a similar prognosis to my Polyclinic pupils who saw the case. Ten days later, that is, two weeks from the time of injury, another incipient bedsore was noticed on the buttocks. The hospital notes of this date say I ordered that change of posture to be frequently made and that she sit up as soon as possible. Six days subsequently she was sitting up in a chair. I am unable to say whether she got out of bed previous to this date or not. The bladder symptoms gradually improved, she soon sat up all day, and on October 4, five weeks after admission, it is recorded that she was walking on crutches. On October 26 she was able to walk a little *without* crutches, though she did not do so much. She continued to gain in activity until her discharge on November 2.

The result was so unexpected to me, for no restraint of motion at the hip was attempted after four days, that I almost mistrusted my diagnosis, and concluded that possibly the resident surgeon's original diagnosis was correct. I had made no investigation of the condition of the limb since she began sitting up. A few days before her dischage, however, I put her in bed, and with my colleague, Dr. Keen, examined her. The leg was strongly everted, as in intra-capsular fracture, immediately after the injury, and she was able to invert it only so far as to make the toes nearly vertical. She could raise the leg, however, and lay it across the other or carry it outward; and, indeed, appeared to have motion of the joints except full inversion, though she stated it was a little stiff when walking. She had no pain. The everted leg, therefore, made the correctness of my diagnosis an established fact. Here, then, in a woman of 78 years was obtained union and a useful limb, despite the absence of treatment. In the face of such result, treatment should always be attempted, and not abandoned unless circumstances, such as arose here, demand its discontinuance. Well-directed treatment will certainly be expected to make many good cures, if no treatment will occasionally give so excellent a limb.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

DISCUSSION ON CASE OF PROBABLE BONY UNION AFTER FRACTURE OF THE FEMORAL NECK.

Reported by G Betton Massey, M.D.

Dr. O'Hara: I assent to the views put forth by Dr. Roberts. I recall a case of a gentleman of 79 years of age, injured on a railroad car in motion, moving his body at the same time to get out on the platform.

A distinguished surgeon pronounced it as hopeless for cure, and, as the patient was so aged, advised nothing to be done for the repair of the fracture. It was diagnosed by both of us as an intracapsular fracture.

Sand-bags and extension were applied. The patient readily co-operated, and barely moved for eight weeks. He had good health, though so old, and to my astonishment he walked in eight weeks without a a crutch. There was very little difference to be noticed between the two limbs, except a slight eversion of the affected one. He used the limb without any trouble until he died, seven years later. The man, for his age, was remarkably healthy, and this might have been other than a fracture of the neck, but those present examining it at the time could make no other diagnosis.

Dr. John H. Packard: From Dr. O'Hara's statement as to the shortening in his case, I should scarcely think him warranted in claiming it as probably one of bony union of an intracapsular fracture.

I regret that I came in so late as to miss the report of Dr. Roberts' case, and the earlier portion of his remarks upon it. The subject is one which has greatly interested me, and I have examined with care all the reports of cases claimed as bony union, and all the specimens accessible to me. [Dr. Packard then illustrated by diagrams on the blackboard, the structure of the neck of the femur, as shown on vertical section.] In all cases of fracture, wholly or partially extracapsular, there is a long point or spur of bone extending down close to the lesser trochanter. When such degeneration takes place, the structure becomes weaker and less marked, and there is a certain amount of fatty change; under these circumstances the bone may give way, even under slight stress, near the head, and across the axis of

the cervix. Now all the cases claimed as of bony union of fracture of the neck of the femur within the capsule, with one exception, are open to the explanation that the fracture was really in part extracapsular; and that the lower portion of the cervical fragment, after union had taken place, became absorbed, so that the head sank down against the intertrochanteric portion of the distal fragment.

The exception was in a specimen presented by Dr. J. M. Adler, in 1869, to the College of Physicians of Philadelphia; it was referred to a committee consisting of Dr. A. Hewson, Dr. John Ashhurst, Jr., and myself, and we decided, after careful study, that it was an example "of genuine bony union of an impacted intracapsular fracture of the cervix femoris."

A year or two since I had the opportunity of examining one of the specimens claimed by the late Dr. R. D. Mussey, of Cincinnati, as of this character, and found the long point of bone, above described, still distinctly marked.

With regard to the treatment of fractures of the cervix femoris, I think we are seldom justified in leaving the cases to nature; only, in fact, when the age and debility of the patients, the occurrence of bed sores, and the restlessness sometimes met with in old people, make the chance of a good result too small to warrant subjecting them to the discomfort and even risk of confinement with extension.

Some years ago I exhibited to the Academy of Surgery a man who, when 62 years of age, fell backward over a pile of boards, fracturing the neck of the left femur. He was tractable and of fairly temperate habits; I treated him at his home, with extension by weight and pulley, and after the first week made him sit up daily in bed. Although I told him he would probably remain always a cripple, he recovered completely, and walked well, even up and down stairs, at the fourteenth week. When brought before the Academy, he had no limp whatever, and could stand on or move either leg indifferently; there was actually nothing, except slight perceptible thickening, to show on which side the injury had been.

About ten years ago I was called to a young man of about 20, who had been thrown from the high driving-seat of a wagon, and sustained a fracture of the neck of the thigh-bone. Dr. Nancrede, who aided me in the dressing, and myself determined the nature of the injury under ether. The man recovered so that within two months he was driving his wagon, as well as ever.

I think that, while we can never confidently promise much in these cases, we ought never to despair, and never be satisfied with anything less than the best attainable results. Unless the unfavorable conditions before mentioned are present in a most decided degree, an attempt should always be made to institute effective treatment.

Dr. Levis: I think Dr. Roberts a little too confident of our ability to make a differential diagnosis in these cases. It is certainly sometimes impossible to do so without making the manipulations which he condemns. In obscure cases, when a diagnosis is important, I place the patient with the face down, and carry the limb back as far as it will go. Normally this distance is but slight, but fracture of the neck of the femur allows much greater motion. It is with regret that I put a patient through this manipulation. The best method to make a differential diagnosis between the two forms of fracture, is by rotating the limb. Normally, the great trochanter rotates in an arc with a radius of the full length of the femoral neck; if there is intracapsular fracture, this radius is but slightly diminished; while there is scarcely any radius in extracapsular fracture, because the centre of rotation is the long axis of the femoral shaft.

Dr. Packard: I feel bound to protest against the employment of needless force, or, indeed, of any violence or rough handling in the diagnosis of fractures. In the case of the hip, if crepitus is once elicited, that should suffice; there should be no further testing nor demonstration of it, lest the fragments be brought into worse position.

Dr. Levis: I never feel assured of the real lines in any case. If the cause is trivial, and there has been no fall upon the trochanter, it is probably intracapsular. If there has been a severe fall upon the trochanter, it is highly probable that it is extracapsular. I do not recall what was my feeling on this point in the case Dr. Baldwin alluded to, but from his remarks would say it was extracapsular.

Dr. Addinell Hewson: I have had experience with both intra- and extracapsular fractures, and have a very good specimen of bony union that was my father's.

In a case at the Pennsylvania Hospital I first demonstrated the value of the contrivance known as the "Lover's Telegraph," for conveying the crepitus to the ear. I have used it frequently, and am satisfied that many cases can be demonstrated by it otherwise difficult of recognition. The surgeon is in too great a hurry usually. In a majority of cases we may have union with some shortening, by using N. R. Smith's anterior splint, keeping the limb so suspended in a semiflexed position at both hip- and knee-joints, and allowing the patient to move in the bed without danger of disturbing the coaptation of the fragments or the occurrence of bed-sores.

Dr. W. S. Forbes: The point alluded to by Dr. Levis—the radius of the arc of rotation—is important. An illustration of its value occurred under the care of the late Dr. Joseph Pancoast, when he diagnosed intracapsular fracture in a young man of 27, owing to a lessening of the arc of rotation on one side. The other surgeons present at the consultation doubted it, having in mind Sir Astley Cooper's saying that he had never seen a case occurring under 30 years of age.* The man died in a week, of mania-a-potu, and the specimen is now in the museum of the Jefferson Hospital, showing fracture of the neck within the capsular ligament.

Dr. Packard: I think that Sir A. Cooper must have been aware of Mr. Stanley's case, that of a boy of 18, which occurred at St. Bartholomew's Hospital about 1830.†

Dr. A. V. Meigs: I recall a case, treated by Dr. Levis, at the Penna. Hospital, three years ago. The patient now walks without a stick. She is 90 years old.

Dr. Roberts, in closing the discussion, said: The discussion this evening shows us that the result of treatment of this accident is much more favorable than has been heretofore taught.

I am glad to know that Dr. Packard believes in the occasional occurrence of bony union. In such cases bony union probably results because the periosteum covering a portion of the neck is untorn, or because the fragments are impacted. If there is impaction you of course have bony union favored for mechanical reasons.

The third point I wish to make is that it is shown, by the possibility of impaction and untorn periosteum, that violent manipulations for differential diagnosis should not be allowed. Should I suffer from a personal infliction of the accident, there would be a very small amount of handling done by my attendant, if I were able to remonstrate.

[The Publication Committee have permitted Drs. Forbes and Packard to add the following notes to their remarks in discussion.]

*"It (fracture of the neck of femur) very rarely occurs under fifty years of age; and dislocation seldom at a more advanced period, although there are exceptions to the rule; for I have myself once seen this fracture at thirty-eight years of age, and a dislocation of the thigh at sixty-two."—Astley Cooper, Surgical Essays, part ii page 35, second edition, London, 1820.

† It was published in the "Medico-Chirurgical Transactions," vol. xviii, as read May 27, 1833.

CLINICAL SOCIETY OF MARYLAND

STATED MEETING HELD JAN. 2ND, 1885.

(Specially Reported for the Md. Med. Journal.)

The Clinical Society was called to order at the usual hour, the President, DR. B. B. BROWNE, in the Chair.

Dr. L. McL. Tiffany related the following:

TWO CASES OF DIPHTHERIA, IN ONE OF WHICH TRACHEOTOMY WAS SUCCESSFULLY PERFORMED.

CASE I was that of a physician, 32 years of age and well nourished. He had contracted diphtheria four days previous to the Doctor's seeing him. Saw him first at 11 P. M.; found him in his shirt, with windows all open in the vain effort to get more air. His pulse was 90; lips blue and dark circles around his eyes; his mouth was a little open and from it a horrible stench came with each effort to breathe. There was no obstruction to the entrance of air and the larynx was not affected; the difficulty in breathing was due to the effects of the poison upon the system and not to any obstruction. She had a gangrenous condition of the pharynx.

CASE II.—A child, male, aged 6 years. Saw it in consultation, at which time there were no patches in the throat; saw the patient the second time the following morning and thought it best to delay the operation;

at 12 M. saw the child again; found patch of membrane in pharynx. While out of the room selecting instruments was hastily called to see the child, who was thought to be dying. The throat was at once opened, artificial respiration employed, but while some froth came from the mouth, no air came through throat opening; the trachea was laid open further down; artificial respiration employed; the child breathed and the immediate danger to life was over. A vessel had been cut and black blood came from it, and it was of much interest to note the arterial hue return gradually as respiration became established. The wound on second day was glazed and soon covered with diphtheritic membrane. It was not thought advisable to put in a tube, but the edges of the trachea were stitched to the skin. An attack of pneumonia followed; the child recovered and the voice returned.

Dr. Tiffany said he would call special attention to two points: the late date of the operation and the fact that the tube was not used. The operation had been put off two days; the child did well without the tube, as he was enabled to get rid of the secretions much more easily than if the tube had been used.

DISCUSSION.

Dr. W. Brinton said the child now was well, and since the operation he had attended the child's sister with diphtheria and now its father had a mild attack.

Dr. J. W. Chambers agreed with Dr. Tiffany in regard to the use of the tube, he thought if a good nurse could be secured the tube should be used, but if not it is best not to use it. He thought tracheotomy should be resorted to the first time marked stenosis of larynx is observed and related a case in point. His cases had mostly died from the passage of the membranes downwards. He has operated fifteen times with four recoveries.

Dr. R. Winslow considered that the proper time for operating was when there was a serious obstruction, but it should not be done too soon. Patient may die from the simple work necessary to breathe or from strangulation. He did not think the discharge could be gotten rid of much faster without the tube. The excision of a portion of the trachea had been recommended to keep the trachea free.

Dr. J. E. Michael said much progress, had been made in this direction, but in Baltimore a great prejudice exists in regard to the operation. He had been called to perform it under circumstances similar to those of Dr. Tiffany.

Four years ago he was called to operate upon a child; the difficulty of breathing was great, but no obstruction to the entrance of the air could be found. In July, 1884, saw a case at Aberdeen, Md.; the girl was 11 years of age and spare; there was evidently obstruction to entrance of air. Immediate relief followed an operation with no bad effects, and no doubt the operation saved the child's life. Recently two cases of diphtheria had been seen by him, both in the same family, one a child of six years, and the other one of four years. The child of six years was suffering from laryngeal stenosis. At the first visit in consultation the patient's lips were rosy and pulse good, and operation was not done; returned at 10 P. M. and found child in about same condition; remained all night and toward morning feared the urgency of the symptoms, an operation was done with instant relief. A tube was introduced. No trouble for one day, when difficulty in respiration increased and patient died. It is important always to impress upon the parents that the operation will not certainly effect a cure. The distinction between difficulty of breathing from obstruction and that from the effect of a poison upon the system must at all times be made. The operation should not be done until loudly called for.

Dr. H. Harlan remembered that Bauchut did operate on all occasions, most of which did well; he made it a rule to make but one single incision.

Dr. J. N. Mackenzie said one point had been overlooked, that was the spasm of the adductor muscles of the pharynx, which should always be eliminated before tracheotomy was performed. In reply to a question from Dr. Tiffany he would diagnose the spasm by means of a small mirror.

Dr. J. E. Michael thought chloroform the best diagnostic means of the existence of spasm.

Dr. L. McL. Tiffany thought it doubtful if any one could eliminate spasm in a very young child. If the loss of voice precedes the pharyngeal diphtheria the result is much more favorable than when the condition is reversed. In the case related,

after the trachea was opened the alæ nasi continued to contract and dilate.

Dr. J.. E Michael said he called to mind a case in which one-half of the nose was dissected off and thrown upon the cheek, and the alæ nasi continued their functions.

Dr. H. Harlan reported

A CASE OF DIPHTHERITIC CONJUNCTIVITIS,

which was as follows: The patient had been suffering a week before the Doctor saw him; the eye was then found red and felt hard to the touch, looking like a case of purulent ophthalmia. The lids were opened when the creamy white membrane was seen, corneæ clear. The child has suffered previously only from some slight sore throat. The eye was dusted with iodoform and iron given internally with a good result.

DISCUSSION.

Dr. I. E. Atkinson thought much depended upon what was meant by the term diphtheritic membranes. He thought it not a very uncommon thing to see upon the lids a membrane due simply to catarrh. The great mistake is that all membranes are looked upon by many as diphtheritic. Not only must the membrane be present but it must be caused by a specific poison before it can be called diphtheritic. The fact that diphtheria is due to a specific organism he thought would be some day shown.

Dr. S. Theobald thought many of the membranes seen upon the conjunctiva are simply due to an intense inflammation, as we find from the use of jequirity. Diphtheritic conjunctivitis is very rare; he had only seen one case and the prognosis was grave.

Dr. A. Friedenwald had had two cases that deserved the name of diphtheritic conjunctivitis; both were in children. In one case the mouth was gangrenous and the child died; in the second both eyes were affected and patient soon died.

Dr. W. T. Councilman thought a great deal of unnecessary confusion had crept in in regard to this subject, and that in true diphtheria there was a necrosis of the mucous membrane beneath the diphtheritic membrane. At Bay View he had examined cases that had died of dysentery, in whom the intestinal mucous membrane was more or less necrosed. In typhoid fever there is oftentimes a membrane to be seen upon the pharynx which cannot be told from that of diphtheria and of which no notice is taken in the books.

Dr Meierhof said he had seen two cases of diphtheric inflammation of conjunctival sac. In the croupous membrane absorbent cotton will remove it, and it will return while in that of diphtheria bleeding will always follow removal of membrane. He then related the two cases noted above; the treatment in the latter was ice cloths freely applied.

Dr. H. Harlan said he well knew the shreds of membrane seen in certain forms of conjunctivitis. When bleeding followed removal of the membrane with swelling of lids and fever he called the trouble diphtheritic.

Dr. W. J. Jones read a paper upon and showed specimen of

HEART FROM A CASE IN WHICH A PRESYSTOLIC MURMUR WAS HEARD IN LIFE.

Dr. W. T. Councilman thought special stress should be laid upon the fact that while there was some stenosis, the autopsy seemed to show that the orifice was large enough to allow the volume of blood to pass. No dilatation of auricle nor evidence of the damming back of the blood upon the lungs could be found.

Dr. C. W. Mitchell said: The presystolic is the most variable of all cardiac murmurs, both as to its intensity and character. At times it is extremely loud and of a rough, grating nature; at others it may be so slight as to be entirely overlooked.

Hilton Fagge reports two cases occurring in his own hospital experience, in which mitral stenosis was found at the autopsy, and in none of which a presystolic murmur was heard during life. A very good method of increasing the intensity of the murmur is to have the patient walk hurriedly around the room two or three times; or if he is unable to do that to have him sit up and lie down several times in quick succession. By these means the heart is made to act more vigorously, and the murmur is necessarily increased in intensity. These methods should be employed in every examination. If, however, no murmur can be heard, the diagnosis can frequently be

made by the great hypertrophy of the right heart; the peculiar thrill felt at or near the apex, and the reduplication of the second sound at the base. I have seen cases in which the diagnosis was made on these signs alone, and fully substantiated by the post-mortem examination.

The remarkable features in the case related by Dr. Jones are the entire absence of hypertrophy, of the thrill and of the reduplication of the second sound. Mitral regurgitation is present in nearly every case of stenosis at this orifice, so that we have, as a rule, two murmurs. In recent cases, however, the regurgitant murmur may disappear owing to still further stenosis of the orifice, so that the valves, though insufficient to close a normal orifice, become able to prevent regurgitation through a narrow one.

Dr. J. W. Chambers said a presystolic murmur had been denied by most authorities. A systolic murmur is caused by stenosis of the mitral orifice, but the auricle does not contract well and he hardly thought a loud sound could be produced by such a weak contraction. In the case related he thought the chordæ tendinæ might have been slightly shortened and thus a murmur be produced. The only positive sign of the murmur is the double sound.

Dr. J. N. Mackenzie said one cause of the mitral murmur, not alluded to in text books, was the passive abnormal insertion of the tendinous chords.

Dr. N. G. Keirle exhibited specimens of

UNI-CORN AND BI-CORN UTERI,

the former by courtesy of Dr. W. T. Councilman; it lacks the left half, a result of none development of the uterine section of Müller's duct on this side. The fundus is of course absent, it being the product of partitional coalescence of the ducts. One variety of these uteri has the neck normal, the tubes having united below, but the upper part being deficient, one or other cornu is absent; these are three-quarter uteri. As a rule such uteri function well though Chiari's case, quoted by Kleb, miscarried at seven months; sometimes there are accompanying arrest, e. g., unilateral pelvis, and one kidney absent on same side as cornu. One hypothesis makes a too wide apart placing of the Wolffian bodies, the proximate cause of this defect as likewise of the abnormalities known as uterus bicornis and uterus didelphis. This specimen of the former is a uterus bi-cornis semiduplex, the septum not extending to the external os, which septum, however short, is the representative of a fundus. The subject of this abnormality, Cath. Byrnes, white, æt. 36 years, had been pregnant as indicated by the os, and abdominal and mammary marks; she died of exhaustion after delirium tremens; her vagina was normal. The embryo at end of twelfth week has a simple vagina and bi-cornu uterus, which is the permanent, full development in many lower animals, carnivora, ungulata cetacea. At the end of the six h week there are only the ununited two Müllerian ducts and a cloaca, which is the permanent, full development in other animals, e. g. fowl and frog; at the end of the eighth week the ducts of Müller are still separated; if now an arrest in direction of normal type occur the development takes on type normal in rodents and marsupials, which is didelphic; this formality is not evinced in normal human embryology, but that it is potentially resident in Müller's ducts becomes evident under conditions of arrest; the subjects (human) of didelphic uteri never survive and other arrests are always present, spina bifida, for example,

Thus circuitously does nature evolve the uterus, presenting actually two types of lower animals and potentially a third, which Chas. Darwin classes as a reversion of organic type, in such language as follows: (*Descent of Man*, vol. i, p. 119): "It is difficult to believe, though not perhaps impossible, that minute, simple, primitive tubes could know how to grow into two distinct uteri and passages if they had not formerly passed through a similar course of development as in marsupials." This indirection in development is likened, by W. K. Brooks, Associate in Biology, John Hopkins University, to a steamer into which a sailing vessel has been altered, this sailing vessel being an altered rowing vessel. Vide *Heredity*, p. 24 and 25.

Practically considered there are reported, from Brirish medical journals (vide *Neal's Digest*,) ten cases of uterus bicornis from the year 1853 to 1874; four of the women had been pregnant, one once; another had had a child at term and in a subsequent pregnancy gave birth to twins, one in each horn, one placenta to each and both pla-

centa previa. This is the case of Dr. Hohl, who detached the placenta, turned and delivered each child; they weighed three pounds apiece and lived a short while.—*London Times* (*Med.*), vol. i, yr. 1854, p. 412. A third subject had borne six children at full term and nothing abnormal noticed. Dr. Ross, of England, was the family physician and delivered this woman of two twins at seven months; two cords to one placenta; four months after she gave birth to a female child at full term; this infant had undisturbedly reposed in that horn the axis of which was parallel to that of the pelvis; in fact there is no dilemma if you steer clear of the wrong horn.

Dr. R. Winslow exhibited a

SPECIMEN OF SPINDLE-CELLED SARCOMA OF THE BREAST REMOVED FROM A WOMAN 73 YEARS OF AGE.

The history of the case is as follows: M. B., colored, 73 years of age, a widow, the mother of ten children, struck her breast against a wash-tub fifteen years ago, that is when she was about 58 years of age. A small lump formed in the outer periphery of the breast, which was but little painful and did not give any trouble until the past three or four years, when it began to increase in size and to be painful. At the time she first noticed the growth she was already long years past the menopause. Her general health was but little affected by the tumor.

When she appeared at the surgical clinic of the Woman's Medical College, in October, the following condition was present: A tumor the size of a small apple occupied the outer portion of the breast; the nipple was not retracted or altered; there were no adhesions to the pectoral fascia, nor were any enlarged axillary glands to be felt. It was painful and her health was running down. There was a discharge from the nipple, which was not offensive. There were no metastases to be discovered. The tumor itself was of firm consistence with one or more points of fluctuation. Operation was declined at this time. About a month subsequently she again presented herself, her condition having very materially changed for the worse in the meanwhile. At the point where previously fluctuation had been felt a protrusion occurred, which bled freely and was offensive. As it seemed about to extrude itself, a little pressure was made upon the breast and a mass of tissue popped out. This was kindly examined by Dr. Abbott under the direction of Dr. Councilman and was found to be a spindle-celled sarcoma.

The condition of the patient grew rapidly worse. A large protrusion occurred, which emitted a horribly offensive odor; the absortion of putrid material caused fever and other symptoms of septicæmia and an operation was rather unwillingly undertaken on Christmas day. The whole breast and considerable healthy skin was removed, the axilla not being opened. Her condition did not admit of any loss of blood, so by means of hæmostatic forceps it was rendered almost bloodless. Iodoform was freely dusted on the wound and it was treated openly. She rallied well from the operation, and has had scarcely a trace of fever since.

Sarcoma is rather a rare neoplasm of the mammary gland, and it is an affection of early life or at least during the functional activity of the breast. It very seldom occurs after the fortieth year. The age is an important point in the differential diagnosis between sarcoma and carcinoma. The former occurring on an average about the thirty-fifth year, whilst the latter occurs about the forty-second or during the decline of the functional activity of the gland. Another point of great importance in discriminating between the two affections is the absence of glandular involvement in the case of sarcoma and its presence in cancer; in cancer also there is adhesion to both the skin and subjacent parts; this takes place to a much less degree in sarcoma. In the case related, notwithstanding the large size of the growth and the length of time it had been in existence neither enlargement of the axillary glands nor adhesion to the pectoral fascia was found.

Dr. Winslow also briefly reported the following case, which presents marked contrasts to the above:

S. V. F., age 30, white, one child, menstruating regularly, noticed a small lump in the upper and outer quadrant of the breast about May, 1883; this grew until in ten months it was as large as a walnut and the seat of lancinating pains. The nipple was not affected and the glands did not appear to be enlarged. The skin was somewhat adherent but the growth glided easily

over the pectoral fascia. Her general health was excellent. The growth was excised and the microscopic examination by Dr. Booker revealed a scirrhus. Recurrence soon occurred in the cicatrix and the glands in the axilla became enlarged. The whole breast was excised at the Hospital of the Woman's Medical College and the axilla opened and a large mass of glands removed from beneath the pectoral muscles, the axillary vein and artery being laid bare for some distance. The extensive wound healed kindly under iodoform dressing.

The age of this patient when first seen (29) was thought to almost preclude carcinoma, and the opinion held by Dr. Winslow was that it was a sarcoma until satisfied by the microscopic examination that it was scirrhus.

Dr A. C. Pole exhibited

SPECIMENS OF INVAGINATION OF THE BOWELS AND THE ENLARGED PANCREAS OF A CHILD.

Dr. J. W. Chambers had seen an invaginated portion of the intestine in a cadaver without there having been any sign of inflammation.

PREPUCE GRAFTING.—*Mr. Clement Lucas* (*Lancet* and *Lond. Med. Rec.*) recommends the use of the skin removed in circumcision of children for supplying grafts to large granulating surfaces, especially those often left after extensive burns. The skin of the prepuce removed from children, for phymosis is peculiarly adapted for transplanting on account of its suppleness, thinness and vascularity. The time which may elapse between the removal of the skin from the prepuce and its use as grafts to a wound may safely extend from half an hour to an hour. If the recipient for the grafts live at a distance, the skin may be conveyed in a small glass bottle or wrapped in gutta-percha without loss of vitality. The author narrates the case of a child, two-and-a-half years old, who was burnt severely on the abdomen, and after some weeks there still remained a large granulating surface measuring 6½ inches transversely and 1½ inch vertically. Mr. L. took the prepuce of an out-patient, whom he had circumcised about half an hour previously, and cut from it about twenty-eight grafts; these were applied to the wound, and in about four weeks the child was quite cured.

Editorial.

THERAPEUTIC PROGRESS.—*Dr. E. R. Squibb*, in a paper on "Modern Progress in Materia Medica and Therapeutics," read before the New York State Medical Association last November, gives an interesting review of the last twenty-five years from the standpoint of an intelligent and observant pharmacist. His observations, as usual, have a highly practical turn and cannot fail to give the physician who reads them many points that will prove useful to him in his daily work. He points out that something may be learned of the progress of therapeutics even from those physicians who do not write for the journals or attend medical societies, and that is by studying their wants as shown by the orders received by the druggist. A study of such orders and the accompanying correspondence indicates that there is a growing appreciation of the fact that success individually and collectively depends upon the real utility of the profession to the public. The age grows more and more utilitarian and demands to see the evidences that disease is being prevented, or if this be impossible sucessfully managed and its damages repaired. The public cares little for abstruse researches or theories but demands that acquisitions of knowledge be applied. The age of expectancy is past and "Young Physic" is no longer a theme of common conversation. The value of medicine may be illustrated even by those not possessing great talents and in situations remote from the intellectual centres. The newest remedies are not necessary in such a work, but the Pharmacopœia, with a simple outfit embracing thermometer, urinometer, litmus paper, test tube and a few reagents with occasionally a plain microscope and sphygmograph thrown in furnish a sufficient armamentarium for the work. Much of the utility of the profession depends upon the value and accuracy of our materia medica.

The value attached to the word cure, both among the laity and profession, shows an important reformation during the period under consideration. The successful treatment of disease or the controlling of disease has taken the place of the old idea. The notion of disease entities has given place to truer and more scientific conceptions of morbid processes. As the doctrine of cure

disappears the utility of remedial agents becomes better established. In another point the present shows improvement, viz., in the emancipation from the idea of arbitrary doses. Physicians are no longer satisfied with the doses of the books. Physiological and therapeutical effects now furnish the guide in estimating the amount of a drug required to secure certain definite results. The difference of susceptibility of individuals or of the same individuals under varying circumstances is now well recognized. Quinia, bromide of potassium and iodide of potassium afford good illustrations of this phase of the metamorphosis. The quality of our remedies has also received increasing attention with the result of securing a much improved class of medicinal agents. Nor does it require expert knowledge to detect adulterations and impurities since the Pharmacopœia, through its full set of officinal test solutions, now places this power within the reach of physicians and pharmacists everywhere. A notable improvement consists in the abandonment of complex prescriptions and the employment of fewer and more active agents. Physicians' orders are short, embracing a supply of not even thirty articles which suffices for common daily use. "Decoctions, infusions, vinegars and wines have almost gone out of use, while tinctures and syrups are steadily falling into disuse though not as rapidly as they deserve. These are all replaced by the far more accurate and convenient fluid extracts with their small and effective doses, which can be so easily administered in so many different ways." In the precision of measuring medicines for administration much has been gained, and accurate weights and measures are now to be obtained without difficulty at a reasonable cost. Perhaps the greatest progress, says Dr. Squibb, has been made "in the power and definiteness of the agents used and in judging of the manner and effect of using." This is illustrated in various ways. On the other hand it cannot be denied that there have been other changes which are not improvements, and much doubtful medication is in vogue which is for the good neither of the public nor the profession..

Recent Progress in the Diagnosis and Treatment of the Diseases of the Female Urethra.—Until within the past few years the diseases connected with the female urethra have remained in as much obscurity as existed in regard to uterine disease before the introduction of Sims's speculum. Indeed the profession at large has, at the present time, but a limited appreciation of the important and distressing influence which urethral diseases exercise upon the female economy. It may be said that much confusion and lack of knowledge still exists in regard to reflex disturbances. It is not at all surprising then that diseased conditions of the urethra should have been overlooked, and the seat of irritation referred to other inflammatory sites in adjacent tissues, when it is remembered how vainly the uterus has been tortured to quiet reflex disturbances which had their origin in ovaritis, salpingitis, or probably in inflammation about the folds of the broad or utero-sacral ligaments. A prominent cause for this want of appreciation of the importance of urethral diseases has resulted from the difficulty in the way of detecting the conditions which may excite trouble in the female urethra. A simple lesion here is likely to escape detection from its concealed position, and the reflex trouble may be more easily explained by referring it to a neighboring organ exhibiting more marked pathological changes. Whilst then the diseases of the female urethra have remained a *terra incognita* to the profession at large, their importance is being fully recognized by specialist in female diseases. To Dr. Emmet undoubtedly belongs great credit for original and valuable contributions to the pathology and treatment of urethral diseases. With great patience and perseverance he has developed this new territory, and has thus placed the profession in his debt for his earnest work in this direction. In the last edition of his book Dr. Emmet treats of the diseases of the urethra in an exhaustive manner. Those who are not familiar with this subject, and who desire to follow the author into numerous details, are referred to this book. We propose only to present briefly a few points in connection with this important subject with the view of interesting others in its study, rather than with any intention of discussing or criticising the views expressed by Dr. Emmet.

Dr. Emmet has doubtless expressed the true cause of our ignorance of urethral disease in the female in the statement that it was "due to a want of means of exploration." The endoscope and other mechani-

cal appliances devised for exploring the urethra, are only partial and imperfect aids to diagnosis. Some six years ago Dr. Emmet devised the plan of making a button-hole like opening in the female urethra for the purpose of forming a diagnosis, or for facilitating operative procedures. It has been due to the use of this method of exploration that we now have an exhaustive and practical study of urethral affections. Dr. Emmet does not now hesitate to announce the fact that this method is the only one within our knowledge to-day which fulfils every indication for exploring the female urethra. In the latest edition of his book Dr. Emmet describes fully this method of operating, and gives a number of illustrative cases showing the results of this plan of diagnosis and treatment. These clinical facts read like words of revelation, and go far to confirm the estimate Dr. Emmet places upon this method of procedure. A classification of the diseases of the urethra shows that this organ may be affected with growths and with thickening from inflammation of its mucous and submucous tissues: "the canal may be dilated from before backward, and with more or less prolapse of the mucous membrane along the urethra from the bladder; its lining membrane may be diseased in part or throughout; or fissures may exist at the neck of the bladder." For these conditions we have had no efficient means to aid in forming a diagnosis, until Dr. Emmet devised this button-hole operation.

The importance then of this operation can be fully appreciated in its general bearing upon the diagnosis and treatment of urethral disease. At first thought the distress and reflex disturbances occasioned by growths, fissures and inflammatory conditions of the mucous membrane of the urethra may appear to be exaggerated phenomena, but we cannot think Dr. Emmet has overdrawn his estimate of the influence these conditions may exercise upon the female economy. Dr. Emmet is known to be a most careful and painstaking observer. The clinical facts he offers carry with them the weight and force of strong conviction.

Laceration of the female urethra is a condition which, perhaps, few clinical observers have recognized; yet Dr. Emmet informs us that since his attention has been called to the subject he has found evidence of urethral laceration as common as that of the perinæum, and far more so than the injury through the sphincter ani. The result of this lesion is a too patulous urethral outlet and more or less prolapse of mucous membrane. This prolapse presenting itself at the outlet of the urethra, projecting from the upper or lower portion of the passage, or occupying the entire circumference of the canal impedes the escape of urine from the bladder, and, as the obstruction increases, more or less tenesmus is constantly excited, which in time adds to to the difficulty. "Ultimately the whole urethral canal becomes displaced, and pressed forward or rolled out, by a prolapse of the super-incumbent tissue about the neck of the bladder."

In the recognition of this condition an important advance has been made in the treatment of urethral troubles.

Urethrocele is another important subject considered by Dr. Emmet. This condition has been frequently attributed to laceration of the perinæum. Dr. Emmet attributes it to an injury of the urethra direct; the laceration of the perinæum preventing a proper support, the condition of the urethra could not improve afterwards, and becomes exaggerated in consequence. He believes in the beginning of every case of urethrocele more or less laceration has taken place between the longitudinal fibres of the urethra. This condition is easily remedied by removing the excess of tissue, and by then denuding the sides of the opening in the urethral tract to a sufficient width, so that when the two surfaces are brought together by sutures the urethral canal will be restored to its natural calibre.

In the study of "Fissures at the Neck of the Bladder" and of "Lacerations of the Urethra from Dilatation," Dr. Emmet has done most excellent original work. The diagnosis and treatment of the first named condition has been so simplified by his button-hole operation that a distressing condition is readily brought under the control of the surgeon.

In the examination of growths on the uterine wall it has been claimed that dilatation of the urethra offers superior advantages. As is well-known this operation is not devoid of evil consequences. Permanent incontinence after the operation will occur in a certain number of cases, as a result of lacerations of the urethra. The consequences which follow such a procedure

are serious enough to give rise to doubt as to its propriety. Dr. Emmet, having given most careful study to this subject, asserts that the alleged advantages in no degree compensate for the risk, particularly since an artificial opening in the base of the bladder gives equal facilities for exploration, and is attended by no such risk of incontinence.

Summing up the present status of urethral diseases in the female it may be said in a few words that great progress has been made in their diagnosis and treatment since Dr. Emmet devised his button-hole operation, a method which has rendered the exploration and treatment of the urethra comparatively easy and successful procedures.

Miscellany.

Poisoning by Sardines.—*Mr. Addinsell* (*Lancet and London Medical Record,*) reports the following case: About 3 P. M., a lady ate four sardines. The box had been opened some days and a small white speck was noticed on one or two of them, but they seemed fit to eat. About 4.30 P. M., the patient was seized with vomiting and diarrhœa. At 7 P. M. Mr. A. found her in collapse, the temperature below normal, pulse extremely feeble and great thirst. Three minims of morphia were injected hypodermically, and a drachm of brandy with a little ice was administered. This was quickly ejected. The evacuations consisted of blood and mucus, but were less frequent. About 9 P. M. half a pint of rice water with an egg beaten up with some ice was given, and by 11.30 P. M. the pulse was distinct. During the night the patient slept fitfully, vomited twice, and had three evacuations. Seventeen hours after being first seen the temperature was normal and pulse fairly good. Recovery was rapid.

Treatment of Nephritis.—*Prof. Cantani* (*Centralb. f. d. gesammte Therapie, Lond. Med. Rec.*) in acute forms recommends expectant treatment, rest in bed with warm coverings, abstinence from fluids, and inunction with oil, followed by packing in blankets. Warm baths may be used to facilitate diaphoresis. Diuretics and purgatives are contraindicated, as they increase the loss of albumen and favor hydræmia. The diet must be bland and milk diet is best. Eggs do not increase the albuminuria. Less acute cases will be benefitted by the employment of tannate of quinine and gallic acid, with alkalies if the urine be scanty, on account of stoppage of the canaliculi. In chronic cases parenchymatous nephritis must be distinguished from interstitial. In the parenchymatous forms attention must be paid to the condition of the skin, and diaphoresis induced when necessary. Meat or fish may be given to repair the waste of albumen, but stimulants are to be carefully avoided, unless absolutely necessary. Gallic acid is to be preferred to tannic for internal administration, and diaphoretics must be used rather than diuretics. Drastic purgatives must be resorted to only when a prompt and temporary action on the intestines is desired, as in threatening uræmia. Interstitial nephritis tending to atrophy requires no diaphoretics or diuretics; oil may be used for the dryness of the skin. Iodide of potassium, recommended by Bartels, has no influence in retarding the hypertrophy of the connective tissue. It may be useful like other alkalies, in counteracting the cardiac hypertrophy. Digitalis is beneficial for the frequent and incomplete cardiac contractions.

Relation of Certain Diseases of the Eye to Gout.—It has been shown to be probable that there are many different forms of inflammation of the eye, or of parts of it, which are in connection with gout. Some of these are very peculiar and specialized types of disease, and have already been accorded distinctive clinical names; others quite as distinct are not as yet so well known, and of others we may say that they are to be distinguished from other inflammations of the same structures not so much by their features as by their cause. Of all we may assert that they are infrequent; some, if we confine ourselves to well marked types, are distinctly rare. We have divided these different affections into two groups: 1, those which go with acquired, humoral or renal gout; 2, those which depend upon the inheritance of structures damaged, or at any rate specialized by gout in predecessors.

It is needless to repeat that in almost all cases of acquired gout there is inheritance also, and that in many in which the disease is chiefly caused by inheritance some modification or increase may have been desired

from personal habits. Still the difference between the two classes of affections is very marked. In the one, attacks of a transient nature are the rule, and these attacks are often acute and attended by much pain. In the second group, although a tendency to temporary recovery and recurrence is often observed, yet there is a great proneness to chronicity and persistence. The invasion is often insidious, but the disease is usually in the end destructive. In the former group we have placed hot eye, sclerotitis, recurrent iritis and retinitis hæmorrhagia. All these are diseases of adult life. In the second group we have insidious disorganizing iritis, relapsing cyclitis, certain forms of soft cataract and perhaps some of primary optic neuritis. Not only are there clearly marked clinical differences between the two classes of affections, but the difference in treatment is equally marked. In the first the well known measures against gout must be taken: a restricted regimen, alkalies, colchicum, and aconite, and liberal counter-irritation. In the second we must use tonics, and although counter-irritants are here also often valuable, we cannot trust to any measure as really curative short of complete change of climate.—*Lancet and N. Y. Medical Record.*

Dr. Austin Flint on the Value of the Presence of the Bacillus Tuberculosis as a Diagnostic Test in Phthisis.—Since the summer of 1882 Dr. Flint has made or had made microscopical examinations of sputa in a large proportion of the cases of lung trouble that have come under his observation, and thinks his experience probably as large in this direction as that of any other. The result of this experience is that he has been lead to place more and more reliance upon this characteristic diagnostic test. He can recite not a few cases in which the history, symptoms and physical signs failed to furnish sufficient ground for a positive diagnosis, but in which the pressure of the bacillus was ascertained, the subsequent history showing that the disease was phthisis. He remarks that we must not be satisfied that phthisis does not exist from the absence of the bacillus in a single examination of the sputa. A negative result in a single examination may be considered as a ground for the presumption that phthisis does not exist; but in order positively to exclude the disease repeated examinations should be made with a negative result.—*Clin. Lecture in Amer. Practitioner.*

Removal of Tumor from the Brain.—Within the last few weeks we have been able to chronicle an invasion of a region hitherto sacred from the surgeon's hand. The doctrine of the localization of motor centres in the cerebral cortex, though it has received striking support from observations in the dead house, and though it has been attended by a great increase in the precision of diagnosis of the locality of lesions of the brain, has received its first application to the relief of disease at the hands of Mr. R. J. Godlee, who has operated on a patient suffering from tumor cerebri; the growth was a glioma, and its situation in the upper part of the fissure of Rolando, had been accurately diagnosed by Dr. Hughes Bennett. The case is of great interest and importance. The patient recovered for a time from the effects of the operation, and the fits ceased; although hemiplegic he appeared to be for some days in a better condition than before the operation. It is much too soon to form any trustworthy opinion as to the exact value of the operation, which was fully justifiable, whatever its ultimate consequences for the patient had given him a chance of life, and of life in a condition not indeed of health, but of much physical comfort and usefulness; as it happened it at least diminished suffering. It is not too much to say that this case marks an epoch in the history of medicine, and seems to demonstrate once more that the danger attending operative interference with the brain has been exaggerated, just as a generation ago the danger of interfering with the peritoneum was exaggerated.—*Brit. Med. Journal*

Excision of Uterus for Cancer.—*J. Wallace, M.D.*, Edin., Professor of Midwifery and Gynæcology in University College, Liverpool, Victoria University, concludes that in the early stage of cancer of the womb, while the organ is still mobile and not enlarged, the operation for excision is justifiable, patients recover, and rapidly regain health and strength; that the vaginal operation is to be preferred to all others, abdominal section enormously increasing the risks, and not being necessary in cases suitable for the operation.

Chlorate of Potash for Burns and Scalds.—*Dr. J. Walton Browne* (*Brit. Med. Journ.* and *Lond. Med. Rec.*) recommends this drug locally. It is especially useful in burns and scalds of the second and third degree as well as in the severe forms of the fourth and firth degree, seeming to favor the formation of granulations after separation of the sloughs. The method is this: In superficial burns the blisters are punctured and bread and water poultices applied every four hours over all the injured surface until the cuticle has become detached; then pieces of lint soaked in a chlorate solution (gr. v to ℥i are applied four times daily. Oiled silk is placed over the pieces of lint. To prevent the lint from adhering to the wound a little glycerine may be added to the solution or chlorate may be made into an ointment with lard (gr. v to ʒ i). In treating very deep burns poultices are applied until all sloughs are separated; then the wounds are dressed with the solution of gr. v to ℥ i and a mixture can be given (if the granulations be flabby) of the chlorate and tincture of the perchloride of iron, at the same time increasing the strength of the chlorate solution to gr. x to ℥ i. The reporter adds that Dr. Harkin spoke of chlorate of patash solution (gr. v to ℥ i) as the very best local application for burns.

Puck's "Realistic Recipe" for "Homœopathic" Medicine:

> A grain of medicine you take
> And drop it in Superior Lake;
> Mix it and stir it thoroughly,
> Then of the mixture in the sea
> Put just one drop and stir it well,
> So neither taste nor touch nor smell
> Of medicine within is found;
> Then take of sugar just a pound,
> And medicate it with one drop
> Of the aforeraid mingled slop.
> Each day three times take half a grain,
> Till you are dead or free from pain.

Chronic Dysentery Treated by Voluminous Enemata of Nitrate op Silver.—*Dr. S. Mackenzie* dissolves a certain quantity of this agent in three pints of tepid water in a Leiter's irrigating funnel connected by India-rubber tubing with an œsophageal tube with lateral openings. The patient was brought to the edge of the bed and made to lie on the left side with hips well raised by a hard pillow. The tube well oiled was passed about eight to ten inches into rectum and the fluid allowed to force its way into the bowel by gravitation. The injection rarely caused much pain, often none. It usually returned promptly; but when long retained it was advisable to inject chloride of sodium to prevent absorption of the silver salt. Various strengths had been used from thirty to ninety grs. in three pints of water, but usually one drachm of the nitrate was employed. The treatment was based on the view that whatever the nature of dysentery, whether constitutional or local, in the first instance, the later effects were due to inflammation or ulceration of the colon, which was most effectually treated as similar conditions elsewhere by topical measures. Sometimes one, sometimes two injections were required, and in some cases numerous injections were necessary; but in all the cases thus treated, many of which had been unsuccessfully treated in other ways previously, the disease had been cured. In most cases other treatment was suspended, but in some Dover's powder or perchloride of iron, which had been previously administered, was continued as subsequently prescribed. The cases narrated were these: 1. Where the disease had lasted several years on and off; two injections were used and the case was cured in six weeks. 2. Second attack, duration uncertain; four injections used; cured in five weeks. 3. Duration two months; two injections used; cured in three weeks and a half. 4. Duration five years; one injection; cured in three weeks. 5. Duration eighteen months; two injections; cured of dysenteric symptoms, but remaining under treatment for diabetes. 6. Duration fourteen months; one injection; cured in seven weeks. The treatment laid no claim to novelty.—*Brit. Med. Journ.*, as quoted by *American Practitioner.*

Dystocia From Coiling of the Umbilical Cord Around the Neck of the Fœtus.—*Dr. Rachel* recommends the following treatment of this complication of labor (*Am. Journ. of Obstet.*): 1. Anæsthetization of patient. 2. Extraction of head by forceps and division of cord to allow delivery of body. Or in extreme cases, 3. Division of cord within vagina followed by the forceps. Early division of cord may be urgently required to save the life of the child, as is illustrated by Lusk's case and one cited by Cazeaux, where it was delayed two hours

after the birth of the head. It also militates against two other formidable accidents, viz., inversion of uterus and flooding.

Medical Items.

Over $8,000 were realized by the recent ball at the Academy of Music for the Hospital of the Women of Maryland.

Dr. Lewis H. Steiner has accepted the invitation to deliver the annual oration before the Alumni Association of the University of Maryland School of Medicine.

Theses designed for competition for the Alumni Prize of the University of Maryland must be handed in by February 7th.

The Locaze Prize of $2,000 has been awarded by the Paris Faculty of Medicine to Dr. Debou for his clinical lectures on tuberculosis.

During the year 1883–84 there were admitted to practice in the German empire 771 physicians, 22 dentists, 92 veterinary surgeons and 393 apothecaries.

The patient from whom Mr. Goodlee removed a cerebral tumor on the 15th of November, died on the 23rd of December, with meningitis. The case has attracted a great deal of attention as it was the first extensive surgical operation ever performed for the removal of tumor of the cortex.

Hydroclorate of cocaine has been pronounced by Dujardin Beaumetz the best therapeutic agent in vaginismus due to inflammation and ulceration of the vulvar orifice.

Dr. Ambrose L. Ranney, of New York city, has been elected Professor of Anatomy in the Medical Department of the University of New York, made vacant by the death of Prof. Darling.

Dr. J. M. Taylor, of Philadelphia, has obtained very good results with nitrite of potassium in angina pectoris. After giving this drug, to a patient very ill with this disease, for four weeks, the patient recovered.

A French "Congress of Surgery" is to be organized, which is to meet annually in Paris. Its object is to establish closer relations between national and foreign savants and physicians interested in the progress surgery. The first meeting will be held during Easter week, 1885.

Dr. Herbert Davis, consulting physician to London Hospital, died January 4th. He was the author of the systematic treatment of rheumatism by blistering.

The *Societe Medicale des Hospitaux*, of Paris has appointed a commission, of which M. Villemin is President, to ascertain the opinion of the physicians of France with reference to the transmissibility of phthisis from those affected with it, or by means of the milk or meat of cattle. Personal transmission is declared to be no longer questioned, but the conditions "exceptional without doubt," under which this takes place, have yet to be investigated.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from Jan. 13, 1885, to Jan. 19, 1885.

Bentley, Edwin, Major and Surgeon, leave of absence extended two months.

Tremaine, W. S., Major and Surgeon, relieved from duty at Fort Porter, N. Y.

Girard, A. C., Captain and Assistant Surgeon, ordered for duty at Fort Porter, N. Y.

Appel, D. M., Captain and Assistant Surgeon, ordered for duty at Plattsburg Barracks, N. Y.

Girard, J. B., Captain and Assistant Surgeon, ordered for duty as Post Surgeon, Fort Schuyler, N. Y.

Howard, Valery, Captain and Assistant Surgeon, on being relieved at Fort Schuyler, authorized to avail himself of leave of absence—four months.

Elbrey, F. W., Captain and Assistant Surgeon, sick leave still further extended six months on surgeon's certificate of disability.

PROMOTIONS.

Lieutenant Colonel John Campbell, Surgeon, to be Surgeon with rank of Colonel, December 7, 1884.

Major R. H. Alexander, Surgeon, to be Surgeon with rank of Lieutenant Colonel, December 7, 1884.

Captain Henry McElderry, Assistant Surgeon, to be Assistant Surgeon with rank of Major, December 7, 1884.

APPOINTMENT.

Jefferson R. Kean, to be Assistant Surgeon with rank of First Lieutenant, December 8, 1884.

Original Article.

SUGGESTIONS, FROM DISPENSARY EXPERIENCE, FOR THE SURGERY OF GENERAL PRACTICE.*

BY CHARLES W. DULLES, M. D.,

Fellow of the Philadelphia Academy of Surgery; Surgeon to the Out-patient Department of the University Hospital, and of the Presbyterian Hospital in Philadelphia.

It has often seemed to me that the experience gained in the many dispensaries of our large cities is not made of as much service to the profession as it might be, and that it would not be amiss if those who have the advantages which these positions afford would occasionally try to put into accessible shape the lessons which they have there learned, and lay them before their brethren for adoption or correction. And, because I have had to learn by experience some things, which it would have been better for my patients if I had found out in some other way, I have thought it might be worth while for me to invite your attention to certain notions in regard to the kind of surgery which occurs in general practice, which I have gathered during the past ten years, and which, if they are correct, may be helpful to others; if they are incorrect, I shall be glad to have criticised.

In order to arrange a somewhat desultory subject in as orderly a way as I can, I shall divide it as follows:

1. The examination and diagnosis of surgical lesions,
2. The cleansing of wounds.
3. The control of hemorrhage.
4. The dressing of wounds.
5. Bandaging.
6. Splints.
7. The sling.
8. Constitutional treatment.

1. THE EXAMINATION AND DIAGNOSIS OF SURGICAL LESIONS.

I trust I shall not be deemed officious in urging the importance of thoroughness and discernment in making up a diagnosis as to what is the nature of the lesion for which one is consulted by a sufferer. Every writer, and every lecturer, dwells more or less upon this point. But, in spite of all that is said and written, mistakes are constantly being made, which greater care would have prevented. I have seen fractures treated as contusions, and contusions as fractures, over and over again. I have seen a patient treated for a fracture at the lower end of the radius with the time-honored Bond's splint, who had nothing the matter near the wrist, but who had a severe and dangerous contusion of the elbow-joint. I have seen hydroceles treated for years as herniæ, and have been called to operate for strangulated inguinal hernia when there was only a hydrocele of the cord, innocent and easy to cure. I have seen a psoas abscess mistaken for a hernia, and over and over again sinuses of the face, due to disease of the root of a tooth, treated in vain as simple abscesses, the recognition of the cause and the removal of the offending tooth being followed by a prompt recovery. I do not care to cite many mistakes of my own, but I cannot forget my mortification once when caught napping by an ulcerated knee, the syphilitic nature of which was indicated and easily demonstrated when a more experienced surgeon asked to see the other leg. On the other hand, I have known lesions to be characterized as syphilitic on what I thought to be an unwarrantable suspicion, and a cross-examination to show that what a patient called a chancre, could not possibly have been the initial lesion of syphilis.

Now, such errors should not be passed over, or hushed up, when we are speaking among ourselves, or we shall miss the advantage of being taught the necessity for constant vigilance and thoroughness in examining our patients.

Of course, this is not the place to discuss the diagnosis of various lesions, but it may be worth while to call attention to the importance of making our examination include, not only the part believed by the patient to be injured, but also the surrounding parts—muscles, bones or joints, as the case may be, for some distance above and below. The opposite and corresponding parts should often be looked at, for purposes of detection or comparison. Nor should we hesitate to call to our aid the probe or the exploring needle, both of which are valuable and harmless instruments in judicious hands.

Two little points, in regard to the sinuses of the face, I would like to speak of. One is the well enough advocated examination

* Read before the Philadelphia County Medical Society, December 10th, 1884.

of the teeth, by inspection and tapping, to detect a state of abscess in the alveolus; the other I do not remember to have seen recommended. This is, to test a suspected salivary fistula by bringing a drop of the discharge into contact with a drop of the tincture of chloride of iron on a white surface—a piece of white paper will do—when, if the discharge contain saliva, it will give the pink color which indicates the presence of the sulphocyanide of potassium, a normal ingredient of saliva.

And, before dismissing this subject, I think a word may be said as to the failure, when one is really at a loss, to get the opinion of some one who is more familiar with our subject than we are. However proper the motives may appear, which lead to this, they cannot avert from the patient the consequences of error or delay in diagnosis or treatment; and I believe it would be greatly to the advantage of our patients and ourselves, if we accustomed them to the idea of having a consultation before a case becomes extreme.

2. THE CLEANSING OF WOUNDS.

My own experience has led me to the belief that this salutary proceeding is sometimes overdone. When we see a scalp wound, or a laceration of the face, covered with a scab, even though it be not a very handsome one, good surgery does not, I think, require us to take it off, unless the appearance of the neighboring part indicates that an inflammatory process is going on under it. Nor, when a crushed finger is enveloped in dry covering of blood and machinery grime, need we think our patient's safety depends upon a thorough removal of these. On the contrary, I should say his rapid recovery often depends upon our letting them alone. But scabs that cover pus may always be removed with advantage; and foul secretions, or accumulations, can only do harm, and must be cleaned out. So the cleansing of wounds is not only an æsthetic, but also a salutary, procedure. As to the method of cleansing, I am a convert to the views of Mr. Sampson Gamgee, who never uses a liquid for cleansing when it is not specially indicated. Careful mopping with dry cotton or lint will do far more than those who have not tried it would image. Rubbing is rarely called for, but just touching with the cotton or lint, and pressing it down with more or less firmness, as the circumstances require. But, when the case demands it, we must not hesitate to rub firmly, even a little roughly, or to pick off or cut off what sticks tight to the healthy tissues.

However, we must not eschew the use of water too tenaciously. It is often indispensable, and, combined with a little permanganate of potash—just enough to make a transparent, pink solution—it is a *sine qua non* in dispensary practice, as a disinfectant and deodorant. This combination, it seems to me, excels every other so-called antiseptic; and carbolic acid, I may say, I never use as an antiseptic at all.

In this connection I wish to emphasize what I think is a very important matter in washing of wounds and sores, namely, that the same fluid should never be used twice; that is, it should not be dipped from a basin and allowed to flow from the wound or sore into the same vessel, and then dipped up and used again, and so on. The best way of washing a wound would be to let the water run upon it from a hose with a regulated force. But almost, if not quite, as good as this, is the plan of having one vessel to hold the wash, and another to catch the drippings, and to apply the wash by letting it fall in a steady stream from a clean sponge or a mass of oakum. The size of this stream, and its force, can be easily regulated by the force with which the sponge or oakum is squeezed, and the height at which it is held. If the dripping mass be grasped in the hand and held with the thumb up, by well-regulated squeezing a single stream can be made to fall from the dependent portion, in exactly the place and way we wish.

3. THE CONTROL OF HEMORRHAGE.

An important part of the preparation of a wound for dressing, is the control of hemorrhage—I do not mean the hemorrhage from large vessels, but that from small ones, such as are usually encountered in the surgery of general practitioners. Our colleague, Dr. Roberts, has, I think wisely, deprecated the routine use of styptics, and I quite agree with him that, for almost all small vessels, the pressure of a well-applied dressing will do all that is needed in the way of controlling hemorrhage. Such a dressing may be made of dry lint, bound on

with moderate firmness—actual tightness is not called for—and often one will have, in a little while, an imitation of Nature's favorite method of healing, by the formation of a scab, made up of the dry blood and the tissue of the dressing. The essentials for controlling moderate hemorrhage are dry dressings and moderate compression. Pressure alone is sufficient to control the bleeding from scalp-wounds, which are sometimes spoken of as if they were troublesome to deal with. It is remarkable, at times, to hear men describe the pains they have been at to ligate an artery of the scalp, in view of the fact that this is never indispensable. A compress and a bandage will control any vessel in the scalp, and almost anywhere else; and, if an unruly patient is likely to pull a bandage off, a pin, even a common one, may be thrust under the vessel and brought out again beyond it, so as to hold it as long as any one could wish. If still greater security be desired, it can be had by adding a "figure 8" to this pin.

And here I wish to add a word as to the need for stopping bleeding. I will go a little further than Dr. Roberts in regard to the innocence of hemorrhages which sometimes cause great uneasiness. Many of these hemorrhages are absolutely beneficial. Of course, one need not be foolhardy, but such hemorrhages as come from superficial wounds may be regarded with the greatest equanimity, and no one need get flustered in trying to stop them. In my own experience, I often encourage bleeding to a considerable extent, as in the case of incisions for felons and palmar abscesses and the like, and have never felt that I lost anything by being deliberate.

Hemorrhage from small vessels can often be controlled by a firm pinch with the forceps, or the vessel may be drawn out and twisted round several times. This will often obviate the necessity for ligatures, in operations such as circumcision of infants or children. Sometimes the arteries in the fingers will bleed in a most troublesome way. If the bleeding cannot be stopped by pressure or torsion, it can be controlled by a pad of lint and a few circular turns of adhesive plaster. Persistent hemorrhage from an alveolus, in one with a hemorrhagic diathesis, I have controlled, when plugging gave only temporary relief, by injecting a fine stream of cool water against the bleeding point. Bleeding from the wound of the palmar arch can, I believe, almost always be controlled by a pad and bandage.

4. DRESSING OF WOUNDS.

Dry Dressing.—Nature's method of protecting wounds is by the process of scabbing; and when we reflect upon the successful way in which this operates in all the lower animals and often in man too, we may wonder that it should be almost a matter of routine to remove scabs in surgical practice. It may gratify our curiosity, it may even aid our study at times, but it is often of no advantage to the patient to remove from a disfigured face, or a cut head, the crusts which are Nature's reliable antiseptic dressings. From what I have seen, I believe it is best to leave such crusts undisturbed whenever possible, and if they are objectionable in an æsthetic sense, simply to cover them with something better looking. Further, it may be said that an artificial scab made with lint, or tarletan, or thin muslin, and collodion, forms one of the best dressings for simple incised and not a few lacerated wounds, which have ever been devised.

In hospital practice, I see many cut heads and simple incised wounds, even after the removal of tumors, which go to a prompt and uninterrupted healing under the first dressing of this sort. Similarly, scabs may be formed by allowing lint to become saturated with the oozing of a wound exposed to the air. Dry powders, such as earth, or bismuth, or calomel, or powdered borax, or boric acid, or iodoform, may be also used to promote the formation of a crust. In all these cases, however, it is important to watch lest the crust bind down offensive discharges, as any scab may do; when this happens, the crust must, of course, be removed, and the wound cleansed.

In the case of strumous ulcers and the weak granulations of large burns, I have had the happiest results from setting aside ordinary dressings, and applying a powder in this way. In these latter cases, I have sometimes practiced exposure of the granulating surface to the air until the serous film covering them has coagulated and formed a species of skin over them. And, to my astonishment, I have seen such a film actually tranformed into thin skin without

displacement. This is a fact which I believe does not accord with the accepted laboratory idea of new skin formation; but it is a fact, nevertheless. And I would especially urge upon others this plan of treatment in the class of cases referred to—old burns and strumous ulcers—which are, I believe, often kept open by the ointments and other warm and moist dressings used to promote their healing.

Water Dressing is another good dressing, which I believe, is too little appreciated. I have seen a number of wounds of the fingers and hands, for example, done by machinery, in which rapid and painless recovery has followed the application of wet lint, which was wetted again, as often as convenient, with a lukewarm, or cool solution of common borax. Patients with such injuries I have often dressed with cold water and told them to dip the finger or hand, as the case might be, in a solution of a teaspoonful of powdered borax in a pint of water, warm or cool, as they found more pleasant, without removing the first dressing.

Lead-water and Laudanum is but little better than cold water, so far as my experience would indicate; although it is suited to cases that are especially hot and painful. But I believe this ought never to be covered up, as it very often is, with impervious coverings. It is not an uncommon thing for me to see a cut hand, or a contused joint, or a painful fracture, covered with lint soaked in lead-water and laudanum, with a piece of waxed paper over this and next a bunch of oakum, the whole bound to a splint with many layers of bandage. My inquiries have usually elicited, from patients treated in this way, the most expressive assurances that they had suffered much, often having passed a sleepless night after these dressings were applied; and I have, I think I may say invariably, found that the suffering disappeared when I changed the dressing for a light lint, dipped in lead-water and laudanum, and held in place by a thin, light bandage, so applied as to leave part of the lint exposed to the air and consequently to evaporation of the lotion, with no splint at all, or the lightest and smallest kind possible. What makes a recent injury hot and air-proof, I have found usually a painful dressing.

Dilute Alcohol is another refreshing dressing, if it be allowed to evaporate, and be removed at the first sign of pain.

Carbolized Oil, which is perhaps not such a very common surgical dressing nowadays, I have found to become very quickly offensive, and I now hardly ever use it. If renewed often enough, it is, however, soothing and healing.

Ointments.—To discuss fully the ointments in use in simple surgery, would require more time than you have to give me. So I may perhaps be justified in stating that the most universally applicable ointment for open wounds which I know of, is one made of equal parts of carbolic acid ointment and oxide of zinc ointment. This has seemed to me to do more good than any other ointment in the case of granulating surfaces, unless they were syphilitic, and in these I think mercurial ointments sometimes do better. A little point in regard to the use of ointments is, that they should be confined, as nearly as possible, to the open surface. A piece of lint or muslin should be spread with the ointment, and trimmed down to the exact size of the sore. If spread on the adjacent skin, it will often, after a while, set up an artificial eczema, which is very annoying to a patient.

The Poultice.—I now come to a subject which has interested me a great deal, and about which I have some convictions, which may be exaggerated, but which are founded upon careful observations made during about five years. One of these convictions is, that the use of poultices is very much overdone. Poultices are of service when it is desired to increase vascular activity in low grades of inflammation, with depressed circulation, and when it is desired to promote or increase pus formation. But I think they do their work in a short time, and that their prolonged use may bring about a condition in which Nature seems unable to get beyond the production of a very feeble and unhealthy sort of tissue. Kept hot and frequently changed, so as to get away the filthy discharges, for a few days they are invaluable; but allowed to cool, left on long at a time, and continued for many days, they do great harm. When a slough is to come away, as after cauterization, or the opening of a felon or carbuncle, nothing which I know of equals a poultice for comfort and effectiveness. But, even in those cases, one should, I think, give them up as soon as the slough is away, and treat the wound as a simple ulcer.

There are no cases which have so much

enforced this conviction upon me as those of deep inflammations of the hand and foot; felons and palmar and plantar abscesses. I have myself seen, and so have those who have followed my service in the surgical out-patient departments of the University and Presbyterian Hospitals, many cases which have illustrated the advantages and disadvantages of the use of poultices in the most impressive manner. Only this autumn I have seen three cases where hands affected with deep palmar inflammation have been almost sacrificed to the persistent use of the poultice—all three of them turning immediately back to recovery as soon as the poultices were laid aside and Nature given a chance to do what she could without them. I may say something similar about felons. I have seen felons, well opened and then too long poulticed, kept unhealed for a long time, the tissues of the finger becoming boggy and of a very low vitality, which recovered promptly when Nature was let alone for a while, and a little attention paid to the general system.

The result of these observations has been that I make but little and brief use of poultices in these troubles. A felon I open deeply whenever I think there is pus actually present—never before, for then they can often be aborted—then I encourage bleeding by a good soak in very hot water; then I poultice for *one day only*, soaking frequently in water as hot as can be borne. After this I dress with pure laudanum, or lead-water and laudanum, or a simple ointment, unless there is obviously a slough forming; and I usually can dismiss my patient in a few days. When a felon has gone on to destruction of the vitality of bone or tendon, poultices may be used longer; but I believe one should be always on the look-out for the time when they can be thrown aside.

The best treatment of palmar and plantar abscesses, or rather of deep inflammation of the hand and foot, cannot be stated in a few words; but alas! for the patient whose doctor is too timid to use the knife, and too assured of the saving grace of the poultice. Too little of the one and too much of the other is a sad combination.

Strapping with Adhesive Plaster for ulcers is a troublesome, though very valuable, surgical procedure. It is common in this country to put straps on only part-way round a limb and to fear the strangulation which may follow going all the way round. But this fear is groundless. In England, straps are applied by placing the middle one at the part opposite the ulcer, carrying the two ends forward, crossing them over the ulcer and fastening them down at the opposite side from which they start; and I have practiced this method myself with perfect safety and success. So much as this, is, however, rarely necessary. A good plan is to apply narrow straps *at intervals* over an ulcer and to place on top of this interrupted adhesive-plaster support, some stimulating ointment on lint—and over all, cotton batting, or oakum, and a bandage. But two things, sometimes neglected, are essential to the best success of strapping: one is, that the straps be not too wide—say about an inch or less in width—another is, that they should draw the sides of the ulcer together a little, and not simply be plastered against it.

The pressure which can be secured with adhesive straps I have also found useful in a number of inflammatory conditions. I need not mention the strapping of inflamed breasts. But the application of narrow straps will also furnish great relief in the case of boils and carbuncles, and I have had a case of paronychia which resisted assiduous treatment for a long while, but in which immediate relief and rapid recovery followed the application of a circular dressing of adhesive plaster round the end of the finger.

Collodion.—This is another agent which may do good service in minor surgery. Many wounds can be easily and effectively coaptated by drawing the edges together, laying over them a strip of tarleton or other bandage, and saturating it with collodion. It should be remembered, however, if one is dealing with children, that collodion applied to a raw surface is very painful for a while. In applying dressings to the face, we may often dispense entirely with a bandage by using collodion in this way, or by placing against a small wound, or ulcer or fistulous opening, a little absorbent cotton and gluing its edges down with collodion. If proper, the whole of the cotton may be painted over with the collodion, and a neat, soft, absorbent, but impermeable, dressing will be made.

Strips of thin material, applied to the surface and painted with collodion, make a good and comforting pressure upon boils

and small carbuncles. Collodion painted directly on the skin is also often very efficient for this purpose. I have found, finally, that styes on the eyelids can often be aborted by touching them with the point of a small camel's-hair brush, dipped in collodion. Of course, care must be exercised, when doing this, not to put any of the collodion in the eye.

5. BANDAGING.

A mistake is sometimes made in bandaging too tight, and I have once seen a case where gangrene was caused in this way. But, fortunately, the time-honored woodcut, which serves in many works on surgery as a warning against this error, furnishes the best information most of us get as to what such a thing is. There is another error, much commoner, and that is bandaging too heavily. I have often seen patients who came with a member firmly bound to a splint, with the laudable object of preventing injurious mobility, but loaded down with successive layers of bandage, until the heat had set up an active inflammation, with the customary accompaniments of pain and swelling, which subsided when the lightest possible splint was used and the thinnest possible bandage.

Sometimes it is desired to apply water after a bandage has been put on. In such cases of course, the bandage should be thin and open-meshed, and put on as loosely as is consistent with safety. For this purpose, the cheap unbleached muslins are far better than the fine ones furnished by the instrument-makers. Water can also be insinuated under a bandage, if the member has first been wrapped in a layer of absorbent cotton or lint.

I think it is a mistake to bandage too far from the seat of an injury. I am sure we sometimes, from the mere force of habit, send a patient away with an imposing surgical dressing, who, if he had not had access to a surgeon, would have done well with a rag tied round his finger or hand. And, in regard to fingers: there is rarely any need to involve the hand and wrist in a dressing intended for an injury to a finger alone. In such a case, it is sometimes desirable to go a little way from the injury; but usually it is sufficient to pass one joint above and below, and to treat separate fingers separately. Sometimes two or more may be bound together for mutual support; but often it will pay, in comfort to the patient, to dress each by itself, and to release at once any one which is well enough to be let alone, and not to keep it waiting upon others.

The placing of cotton under a bandage has other uses than to facilitate the application of water. One of the most important is, to exert uniform pressure, to prevent swelling, to promote absorption of effusions. One who has not tried it systematically would hardly believe what this sort of compression will accomplish; and I think it might be set down as a rule, that all contusions of joints, and most inflammatory swellings, should be subjected to the equable compression and gentle warmth of dry cotton and a pretty firm bandage. Here again I have found it advantageous to follow the suggestions of Mr. Sampson Gamgee, and have come to prefer this method to the traditional lead-water and laudanum.

Before leaving the subject of bandaging, I would like to call your attention to a method of applying a bandage to a limb, recommended by Mr. Sampson Gamgee, which does away with the need for making "reverses," and which makes a much better bandage in many ways than the ordinary one. Two of its advantages are, that it is easier to apply and much less likely to slip. The method of its application is simply to begin at the distal extremity with a few circular turns, and then go up the limb without reverses, and letting the bandage go where it will, always resting smoothly against the surface. If allowed to go where it will, it passes spirally up to the next joint, turns naturally pretty straight round below this, and descends in another spiral, crossing the first with a sort of lattice-work until it reaches the bottom. Here it will go round again and incline upward to repeat the former course. The least guidance imaginable will cause the bandage to cover the spaces left open by the previous spirals, and the limb is covered in smoothly and evenly, and as thickly and firmly as the operator's will and the length of the bandage permit.

6. SPLINTS.

I have already once or twice incidentally indicated what I think to be an important point in regard to splints, and worthy of

more particular mention—I mean their weight. A splint should be no heavier or thicker than is absolutely necessary. The lighter the better, is, I think, a good principle. Let light pasteboard be used when possible, or the very thinnest wood. Nor need their weight and thickness be increased by padding. This is especially true in regard to splints for the arm, where wooden splints are oftenest used. I find it sufficient to wrap a thin wooden splint in waxed paper, to make it perfectly smooth and keep it clean, and to interpose between it and the arm a double strip of lint. These I fasten in place, on the arm, with three or four strips of adhesive plaster, avoiding the seat of fracture or other injury, and covering all in with a light bandage. Then the parts can be examined at any time by simply removing the bandage, without taking off the splint or disturbing the seat of the injury. Of course, little wads of cotton may be placed where the member does not touch the splint, and bony prominences must not be pressed too hard against it.

And here I wish to urge upon your attention what I think the best splint for the forearm and hand. Since adopting it, I have found that, like many other supposed discoveries, it is by no means new. But it is so little used that I think it can hardly be much better known to many others than it was several years ago to me; I mean *the posterior, straight splint*. Any one who studies a forearm will see that when the hand and finger are extended, the dorsal surface is almost an accurate plane, while the ventral surface is very uneven. Arguing from this, I thought it well to follow the apparent hint of Nature, and to use this surface for my splints. I soon found that I could treat injuries of the forearm and hand, requiring a splint, very successfully with a thin, straight splint, applied in the way just described. And I may say that I have found it much easier to prevent stiffness of the wrist-joint—the bane of fractures at the lower end of the radius—by this, than by the time-honored Bond's splint, which I have not used for several years. With the Bond's splint I have, in former years, had much trouble from stiffness, and seen much trouble when it has been used by others, because, while the position of the hand seems to be favorable to motion, I have not found it really so, but that the patient's fingers are either bound to it too firmly, or they themselves clasp the block so constantly and so rigidly, in spite of all injunctions to the contrary, as to tend to stiffening of all the joints involved. I need scarcely add to what I have already said, any further arguments as to the advantage of the posterior splint in the way of lightness and the facility it affords when used in the way I suggest, for examining the seat of injury without disturbing it. The Bond's splint, on the other hand, as frequently applied, is heavy, hot, more or less painful, and troublesome to remove for subsequent examination.

7. THE SLING.

I cannot close these remarks without saying—what my observations, lead me to believe is not uncalled for—a word about slings. It ought to be an invariable custom—with those rare exceptions in which for the purpose of drainage it must be reversed—to have a sling so regulated that it will *support the hand at a higher level than the elbow*. A neglect of this very simple, and, I believe, very important, rule is sometimes followed by great pain and swelling of the hand, and a degree of discomfort which would be incredible to one who had not investigated the matter. Further, a sling should be broad enough to support more than a narrow strip of the arm, or one will be apt to find its position marked by a furrow dividing two swollen parts of the arm, in a manner which is not neat, and which suggests possible injury or interference with the most rapid recovery. Another point about slings concerns the length of time they should be used. Here, again, I think our routine is sometimes too rigid. It cannot be stated exactly how long a sling may be useful; but I have often found it of advantage to let an arm be taken out and allowed to swing at the side, at least occasionally, long before the splint could be dispensed with. If any of you who have not done so already, will try this plan with your patients, I think they will thank you for it, and that neither they nor you will regret it.

There are other matters which have occurred to me in my hospital and private experience, of which I might speak, if I had time and you had patience enough. But I must close with one suggestion, which I think of too great importance to be wholly

omitted; this is: never to neglect, in treating a surgical injury, the constitutional condition of a patient. I have rarely seen a surgical case which was not the better for some medical treatment. A look at the tongue, and a question or two, will usually convince us that a patient will be helped by having the bowels cleaned out with a brisk saline purge. In almost all inflammatory conditions, such as carbuncles, abscesses, felons, deep palmar or plantar inflammations, it is my invariable rule to order a saline purge and follow it with full doses of the tincture of the chloride of iron, or of Huxham's tincture. Quinine I do not use, because, for some reason which I cannot give, the preparation of bark seems to do more good.

And with this I close my remarks. I trust they may not be thought too trivial to have occupied your attention, or too dogmatic, in view of what may be very different opinions on your part. They are, as I have said, notions which I have acquired from my own experience, and which, if correct, may help others, and if incorrect, I shall be glad to have made right.

3932 Locust St.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

STATED MEETING HELD DEC. 10TH, 1884.

DISCUSSION ON SUGGESTIONS FOR THE SURGERY OF GENERAL PRACTICE.

Reported by G. BETTON MASSEY, M.D.

Dr. John H. Packard, in opening the discussion, said: The ground embraced in Dr. Dulles's communication is so very extensive, that it hardly admits of full discussion; but indeed, what I shall have to say is not so much in the way of unfavorable criticism as of endorsement and addition.

First, as to salivary fistula: while admitting the ingenuity of the proposed test, I think it would be in many cases rendered doubtful by the difficulty of procuring the discharge unmixed with saliva.

In wounds of the face, one important object is the avoidance of unsightly scars; and hence the removal of scabs or crusts of blood is often imperatively called for, in order that the surgeon may assure himself of the proper coaptation of the edges.

I endorse entirely what Dr. Dulles says of the propriety of cleansing the surfaces of wounds with water. A very handy way of doing this, especially in private practice, is by means of a syringe, which need not be very large. An article known as "Hall's Health Syringe," may be used to advantage; the liquid to be used being placed in a bottle, and not coming in contact with the bulb or valve, so that medicated washes may be employed without damage to the instrument itself.

As to hemorrhage, I would qualify what Dr. Dulles has said. We are not, in my opinion, as a general rule, justified in closing a wound until the bleeding has been completely checked; hot water will generally effect this, or if there is a small vessel spouting, a serre-pin may be applied for a short time. Whenever prompt healing is to be aimed at, clots should be carefully removed before bringing the edges together. In saying that it is well to allow some blood to flow from a wound, and to empty the vessels in its neighborhood, Dr. Dulles is in accord with Paré. who, three hundred years ago, recommended such a course after the performance of amputation.

I concur with Dr. Dulles in his condemnation of the careless and slovenly use of styptics, and especially of the tincture of chloride of iron. During the late war, in the military hospitals, I many times saw wounds stuffed with this article, forming a mass of mud which had to be dug out, the bleeding continuing beneath it. Some of the gentlemen here to-night, I know, shared this experience.

One of the best and cleanest styptics, known as that recommended by the elder Pancoast, consists of potassium carbonate, soap, and alcohol. It has the disadvantage of causing very sharp pain for a few moments after it is applied, but it is very effectual. In cases of alveolar hemorrhage, a method which I have found useful, is to make a small cone of cork, cover it with "styptic cotton," and press it into the cavity. Such a plan might answer also in cases of pus oozing from vascular bone after the removal of sequestra; but hot water generally suffices here.

Hemorrhages from either palmar arch ought, in my opinion, to be dealt with by cutting down upon the wounded vessel, and tying it on either side of the orifice, or securing both ends if it is divided. I have

seen so much trouble from less decided practice, resulting at last almost always in a resort to the procedure just named, that I believe it to be the best surgery to adopt the latter in the first place.

With regard to dressings, I think lead-water and laudanum very valuable, but it needs to be sufficiently diluted, so that absorption may take place, otherwise it simply shrivels and corrugates the skin. A very large list of ointments, vaselines, with or without morphia, resin cerate, compound elemi ointment, etc., might be added to the small list given by Dr. Dulles.

In cases of painful ulcers, or raw surfaces in healing wounds, which have sometimes exquisitely sensitive spots, the covering of such spots with a little piece of the "skin-plaster," sometimes called "gold-beaters' skin," will often afford efficient protection, and allay the pain given in dressing.

A form of poultice which has given me much satisfaction is the "dry poultice," consisting of an even sheet of raw cotton, applied warm to the part, and then covered with oiled silk, oiled calico, or waxed paper.

Collodion is rendered much more efficient by the addition of gtt. v of castor oil to each $f\,\mathfrak{z}$ i. This gives it a slightly unctuous or greasy feel, and makes it both more flexible and more adhesive.

Bandages are perhaps often applied too tightly, with the idea that they will retain their hold better; yet we very rarely see serious damage done in this way, and I think the more common error is to bandage so loosely as to fail of giving the parts proper support.

It seems to me the practice of confining the rest of the hand, or a large portion of it, in cases of injury to a finger, is eminently judicious; the patient is very apt to use the hand so freely, if this is not done, as to interfere with the well-being of the injured member.

With regard to the padding of splints, I think cotton is very often improperly used. It ought to be in very even sheets, of carefully adapted thickness, and should be changed at once when it becomes sodden and lumpy with perspiration. I prefer it decidedly to the coarse and thick oakum sometimes employed. I have often used a doubled fold of what is known as Canton flannel, for the lining of splints, with satisfaction both to myself and to the patient.

I would like to ask Dr. Dulles, if, in fracture of the middle of forearm he would apply a dorsal splint?

Dr. Dulles: I would in some cases.

Dr. Packard: I think that in the application of a single splint to a fracture of one or both bones of the forearm near the middle, there would be danger of loss of the interosseous space by pressure of the bandage, as well as of irregular union of the fragments by the rotary movement allowed to the part. The latter can be prevented, however, by the simple device of extending the splint up along the arm, with an angle at the elbow.

The subject of the so-called Barton's fracture (in reality Colles') is too large for me to take up now; but I must say that I cannot see how such injuries can be efficiently treated with the dorsal splint. Good results have been claimed to have been obtained with every one of the various forms of splint proposed for the treatment of these fractures; but the fact is that the mere restoration of the use of the arm has been regarded as a good result. I have seen many cases which had been treated by the most careful surgeons with Bond's splint, for example, and in every one there was a marked deformity, and a certain loss of power of flexion, remaining at the end of many years; in some there was also notable weakness, especially in the action of pushing. I think we ought only to be satisfied with the most perfect attainable results; with the restoration of the broken limb to its exactly normal shape, its full power, and its free motion, as nearly as it is possible to us to effect it.

Dr. S. W. Gross: The ulcers, alluded to by Dr. Packard, characterized by a great deal of pain, may be found in other than syphilitic subjects, although they are especially frequent in such cases. The pain is caused by the exposure of the nerves in the granulating mass. By finding the sensitive points, the pain may be relieved by dividing the nerve trunks with a tenotome, applying nitric acid and then a watery solution of morphia and chloral.

I don't think Dr. Dulles wants blood to remain in a wound; it keeps the surfaces apart and furnishes material for decomposition and its consequences. I quite agree that no haste should be made in taking up small arteries, but am not prepared to endorse the statement that all hemorrhages of the palmar arch can be treated by pressure

alone. I cannot but think he would tie the principal arteries. In treating such a wound it becomes a duty to arrest hemorrhage by ligature, acupressure, or other precaution, with subsequent application of the roller bandage.

To prevent gangrene, the roller bandage should be applied carefully and removed after the first eighteen hours. The compress then readily remaining in place from adhesion, the bandage may be reapplied lightly. If hemorrhage becomes imminent, an excellent tourniquet is the flexion forcibly of the bandaged elbow.

I enter a protest against the wholesale denunciation of styptics of the previous speakers. I do not think the surgeon should apply Monsel's solution when ordinary measures will answer, but there are certain wounds in which styptics are absolutely necessary. Thus, in a case of removal of the hypertrophied tissues of the palate, the surface was bleeding severely, the blood coming from the posterior palatine artery, where it was impossible to apply a ligature or the hot iron, a watery dilution of Montel's solution was applied on cotton, and firmly pressed against the bleeding part with the finger, with immediate results in stoppage of hemorrhage. The importance of black heat as a hæmostatic is too little appreciated.

Dr. Packard: I desire to say that I did not denounce styptics, but merely their improper use.

Dr. R. J. Levis: I have been interested in the recommendation of the dorsal splint. If the simple straight splint is to be used at all, it should be placed on the dorsal aspect of the arm, as this side more nearly corresponds to a straight line than the palmar surface. With regard to fractures of the radius at its lower end, none can be treated by an anterior or palmar straight splint, without great deformity occurring, due to forcing upward of the lower fragment and destruction of the natural concavity of the lower surface of the bone. The dorsal surface being less concave and more nearly a plane, is more readily adapted to the straight splint.

If Bond's splint were turned upside down it would serve its purpose almost better than as it is usually used.

Dr. John B. Roberts: The value of the paper just read is shown by the fact that each speaker discusses a different point. There are two or three not yet reached. Very incidental mention of the exploring needle was made. I always carry a hypodermic syringe with glass cylinder which acts well as a suction syringe and is preferable to the exploring needle. In following hospital practice one may see poultices frequently misused and giving rise to large, flabby sores, requiring subsequent use of astringents. I am sorry that I have to differ from my friend, Dr. S. W. Gross, as to styptics. These are generally useless, and if not useless, inefficient. When they are used with pressure, as in Dr. Gross's case, it is usually the pressure that stops the bleeding. The thumb alone would have been sufficient, or the absorbent cotton. Splints are almost always kept on too long. I always use, for fracture of the lower end of the radius, a Levis metal splint, kept in place two weeks, then I apply a strip of plaster around the wrist to give a little support and remind the patient that his wrist has been broken. I believe no possible use can be found for Bond's splint. Nothing has been said, to-night, of moulded splints. A good moulded splint is made of gutta percha soaked in hot water, but the resultant sweating, caused by it allowing no evaporation, is an objection.

Dr. Addinell Hewson: I had the good fortune to see Dr. Bond apply the Bond splint for the first time. He always insisted that the elbow should be above the shoulder and the hand in middle pronation-supination. The side piece was shorter, and a cavity was made for internal condyle. He made the patient grasp the splint firmly during the process of reduction of the fracture.

Another point I may notice is forced flexion at elbow or knee-joint, for arresting hemorrhage. This will nearly always succeed.

Finely powdered white sugar, sprinkled over a bleeding surface, is an excellent styptic, without the disadvantages of some. The sugar should be used powdered, not granulated.

Donna Maria gauze, applied in strips across a wound, and secured at its ends by collodion—a most excellent device of the late Dr. Paul Beck Goddard—gives us the advantage of seeing how well the coaptation of the edges is effected and maintained.

Dr. Geo. E. Stubbs: I have been very much interested in the paper of the evening,

and appreciate the value of the points brought up by the surgeons present. I differ from Dr. Roberts as to the use of exploratory needles. In deep-seated abscesses, the grooved needle is better, because the groove affords an immediate guide to the knife point, if pus is found.

In cleansing wounds, the so-called "household syringe," on account of the gutta percha ends keeping free from rust, is excellent.

In this age of germ discoveries and theories, the water used should be boiled, or at least carbolized; especially if it is derived from the Schuylkill. Where there is inflammation, the lead and laudanum wash is almost always useful. As an ointment, Goulard's cerate is useful. In sluggish ulcers of a specific character, I have found an ointment of iodoform, acetate of lead, ether and cosmoline, preferable. As to the use of styptics, in the late war, I had the same experience in the use of the persulphate of iron and Monsel's salt as has been mentioned, namely the formation of mud-like masses. I have been troubled with the same collections in arresting epistaxis, and have found that the removal of the mass would bring on a fresh hemorrhage. In such cases I have found that the inside, the fatty part, of a bacon rind, smeared with tannic acid, or a common, soft lamp-wick, similarly treated, and pushed into proximity to the part affected, arrested the hemorrhage at once, without any after-trouble.

Dr. Davis: I have seen the straight splint, without padding, used quite considerably in one of our hospitals, and it always flattens out the surface very much, and often causes ulcerations of the projecting bony points, as the knuckles, wrist and condyles. Cotton has been advised, instead of oakum, as a packing material. Oakum, I think, is better, as it does not pack so quickly, and retains its elasticity longer. Instead of extending the dorsal splint up the arm to prevent its turning, as suggested by Dr. Packard, the end near the elbow may be cut away on its inner side, leaving a projecting arm on its outer side, which passes backward beyond the humerus, thus preventing the splint rotating. In using a straight dorsal splint for fractures of the forearm, I have followed the plan of Roser, of Marburg, who extended the splint beyond the flexed wrist, and filled up the space between the back of the hand and splint with wedge-shaped pads. Bond's splint is often unsatisfactory, and even dangerous, from its tendency to flatten out the ball of the thumb, and twist the thumb backwards. I have seen some marked examples of this.

Dr. Dulles, in closing the discussion, said: Mr. Gough used to say, in the introduction to one of his lectures, that he selected his subject as a peg on which to hang his thoughts; in like manner, I feel that, if my paper has served no other purpose, it has been useful in furnishing a peg on which those who have followed me have hung very valuable thoughts. The hour is too late to permit a reply to all the opinions which have been expressed contrary to those of my paper, and, besides, in all of them I have only received the discussion, and in some the correction, which I asked for. One or two points, however, I would briefly refer to. First, as to the use of the hypodermic syringe, instead of the exploring needle. I have used the former at times, but I prefer the latter, because it is easier to clean, and I feel a little safer in employing it, for this reason. Second, as to the treatment of painful ulcers. I have found it very useful to cauterize these—which in a large number of cases are syphilitic—thoroughly with strong nitric acid, and then dress them with oil or an ointment. According to my observation, this is usually followed by complete relief from pain as soon as the pain of the application, which does not last long, passes away. Finally, in regard to the production of ulcers by the straight splint, which has been mentioned as an objection by one of the speakers. I think it is safe to say that, whenever a surgeon finds the use of any apparatus causes ulceration, it is wise for him to abandon it. But, in my own experience, this result has never followed the use of the straight splint. Further, as to the efficiency of the splint: I have used it now for about three years, without accident, and with such good results that, notwithstanding any theoretical considerations to the contrary, I have no hesitation in continuing to use it, or in recommending its use.

The British Gynecological Society has recently been organized in London with Dr. Robert Barnes as Honorary President and Dr. Alfred Meadows, President.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD DEC. 22ND, 1884.

(*Specially Reported for the Md. M.d. Journal*).

The meeting was called to order at 8.45 by the President, Dr. E. G. WATERS. There were twenty members present.

A CASE OF PUERPERAL CONVULSIONS.

Dr. H. F. Hill reported the following case: Was called in about three weeks ago to see a lady in labor with spasm; gave chloroform, after which she did not return to consciousness, but spasms returned whenever chloroform was withdrawn; os rigid; applied cocaine and dilated with fingers sufficient to introduce instruments, and, after several hours, delivered, but the os was ruptured; skin hot and dry; convulsions continued for five days, but were not so frequent.

DISCUSSION.

Dr. Erich said such cases are usually fatal, the common cause being kidney trouble. He was sorry Dr. Hill did not examine the urine. When he was a beginner, bleeding was considered the proper treatment, and he never lost such a case while he bled; now hypodermic injections of morphia is considered the proper treatment.

Dr. Rohe said chloroform and morphia will check convulsions, but they will return again. He thought the proper treatment would be diaphoretics, such as hot baths, jaborandi; etc.

Dr. Pennington mentioned a case of a boy with uræmic convulsions following scarlatina. The fluid extract of jaborandi, administered hypodermatically, relieved spasm promptly.

Dr. Earle related a case of puerperal convulsions following confinement on third day, which was relieved promptly by bleeding.

Dr. Hill said the treatment in his case was rational. He did not use morphia because he expected the convulsions to stop after delivery; he did not use it after delivery because it would relax uterus, and thus favor septic absorption; he purged the patient freely and gave fluid extract of ergot in half drachm doses for several days.

Dr. Erich said he bled to prevent bad effects of the convulsions. Ergot is the best remedy to prevent septicæmia.

Dr. Taneyhill said one of the remedies of the future, and with some at present, is Norwood's tincture of veratrum veride, and he related a case in which he had used it hypodermatically with success.

Dr. Chambers said he would hesitate to give veratrum viride hypodermatically for fear of poisoning. He would recommend it to be given by the mouth.

Dr. King reported a case seven months pregnant having malarial fever. He gave quinia twenty grains per day, in five grain doses. Several days later she miscarried. He had had also a similar case treated similarly, with the same result. He asked if quinia would cause miscarriage.

Dr. Taneyhill said quinia will cause miscarriage and will also cause relaxation of a rigid os in confinement.

Dr. Erich said it is a mooted question whether quinia will cause miscarriage or not. It will shorten labor, but he doubted if it will cause abortion. He has used it frequently during pregnancy in three grain doses; it hastens labor by restoring the woman to her natural strength.

Dr. Ellis said he had seen quinia produce abortion, but by combining small doses of opium with the quinia we can prevent this. Dr. E. mentioned the case of Rose Montgomery; being kicked by a negro at McMurray's pickling establishment, she showed no signs of injury but had violent convulsions. Thinking they were hysterical he gave valerian, etc. The convulsions lasted five days. He mentioned this case to show that there were other causes for convulsions besides kidney trouble.

Dr. J. T. Smith thought quinia would do no harm in the majority of cases.

Dr. P. C. Williams had had no experience with quinia to convince him that it will cause abortion; he never hesitates to use it when pregnant women have malaria.

Dr. Erich said he wanted to point out the difference between hysterical and puerperal convulsions; they are not the same as Dr. Ellis would lead us to believe.

THE TREATMENT OF IRRITABLE BLADDER IN THE FEMALE.

Dr. Erich read, as appointed, a paper on the above subject. He mentioned the cause

and the treatment of acute cystitis, etc. The best treatment is Dover's powder. After the urine becomes alkaline other remedies are needed. The following has been found serviceable:

℞. Benzoic acid, ʒi
Biborate sodæ, ʒiss
Aquæ, ℥ vi
M. Sig. A tablespoonful three or four time a day.

Dr. Gibbons mentioned a case of chronic cystitis in which benzoic acid, as recommended by Dr. Erich, was used with success.

Dr. Roseberry had used the same remedy with good results.

Dr. P. C. Williams said the female urethra admits of very great dilatation. Sometime ago he had met with a case in which the vaginal speculum easily entered the urethra. He suggested injecting benzoic acid into the bladder instead of giving it by mouth.

Dr. Roseberry mentioned two cases in which no vagina was present and copulation took place through the urethra.

Dr. Erich said some cases of rapid dilatation result badly. He uses uterine dilators. Thinks it is better to make an opening in vesico-vaginal septum to remove stones and foreign bodies; does not favor washing out bladder, as it usually does harm.

Dr. Chambers said Dr. Williams's case was the largest urethra he had ever heard of in a woman who had borne a child; cases mentioned by Tait had no vagina.

On motion, the Association then adjourned.

Portable Antiseptics.—Mr. T. E. Hayward (*Brit. Med. Journ.* and *London Med. Rec.*) suggests a plan of preparing corrosive sublimate so that a portable antiseptic can be carried with ease by general practitioners. If ten grains of corrosive sublimate and ten grains of chloride of ammonium (muriate of ammonia), both as powder, be carried in the pocket, wrapped around with gutta-percha tissue to avoid deliquescence, a solution can be readily obtained, as the powder will freely dissolve in water; and thus by adding one of the powders to a pint of water a solution is obtained of the strength of 1 in 960. A few of these powders can be carried in the pocket-case with more safety than the solution in glycerine, lately recommended by Sir Joseph Lister.

Editorial.

Diseases Produced by Sewer-Gas Poisoning.—*Dr. F. G. Morrill* has an article on this subject in the *Boston Medical and Surgical Journal*. He believes that this is a not infrequent source of many of the common affections with which we meet, or if not actually causing may protract them and add to their gravity. He cites instances in which this seems to have been the etiology of recurring tonsillitis, neuralgia, rheumatism, pneumonia, gout, asthma, and nervous prostration. The strong probability of this origin is made apparent by a perusal of these cases. The paper is highly suggestive, and it is well that we should be reminded of this possible source of the diseases with which we daily meet, and of the fact that the services of a plumber may become of more value than many prescriptions.

"When we are called to a case of typhoid or diphtheria," says Dr. Morrill, "we at once order an inspection of the drainage and plumbing, and are seldom disappointed in finding defects, but I am convinced that we ought also to do this in many other cases of diseases which are as yet merely suspected of being infectious, and in some to which no suspicion is attached. Sewer-gas poison seems to seek out the patient's weak spot, and often brings discredit upon the physician whose inability to relieve his patient is due to his failure to appreciate its unlimited powers of mischief."

The Progress of Cremation.—The rapid progress which cremation has made of late cannot have escaped the notice of intelligent readers. From every quarter come reports of formation of cremation societies and erection of crematories, and the opposition to the innovation seems to be dying away before the force of argument and the light of experience. We cannot but contrast the comparative indifference to the measure which now prevails with the fierce opposition which greeted its proposal only some three or four years ago. With the growth of sanitary science, still as yet in its infancy, the incineration of the dead will be placed upon a scientific basis and will become in time, no doubt, the accepted mode among civilized nations of disposing of human remains. Indeed is it not within the bounds of reasonable probability that before the

close of the present century it will be imposed by law, at least in the case of infectious diseases if not in all cases.

One of the best signs with regard to it is the advocacy of it by clergymen. A few days ago a prominent Methodist divine read a paper advocating cremation before the New York Cremation Society, and one of the best addresses on the subject that we have seen was delivered by Rev. J. Max Hark, pastor of the Moravian Church, upon the occasion of the dedication of a second crematory at Lancaster, Pa., on the 25th of last November. The latter gentleman showed very conclusively that the Bible nowhere prescribes burial as the proper method of disposing of the dead "any more than it does other methods and modes of action which are determined by climatic, geographical, sanitary and other considerations, or are left to local or personal taste, custom or tradition." The fact that the Hebrews practiced burial makes it no more incumbent on us than polygamy, abstaining from pork, living in tents, circumcision and slavery, which were equally prevalent among them. The Rev. gentleman further shows that the Hebrews did not scruple when occasion demanded to adopt other methods, as in the cases of Joseph and Jacob, who were mummified, and of Saul and his sons, who were burned. He further points out that the ancient mode of burial was by embalming and placing the bodies in natural or artificial cave chambers and that the modern repulsive method of earth burial was only adopted by Christians about 400 years after Christ. The Rev. gentleman proceeds to show that modern earth burial is the artificial method because it interferes with nature's process, which consists in a slow burning or decomposition, and that cremation is the natural process merely accelerating the combustion which otherwise would take months to accomplish. He further points out the illusion connected with the idea of "peacefully sleeping" in the grave and the horror and loathsomeness connected with the putrefaction which goes on for years beneath the earth.

When we remember the power of religious belief and practice, we cannot but acknowledge the great weight of arguments and addresses from such sources.

At Lake City, near New York, the corner-stone of a crematory has lately been laid. The building will be built in the style of an ancient Greek temple; there will be four retorts, and the cost for cremating bodies will be $35 each.

A Society has also been organized in New Orleans, and ground has been purchased for the erection of a building. Persons of all nationalities and religions are included in its membership, the Hebrews predominating, and preachers of all denominations are said to approve of it.

Even in Baltimore, with its well-known conservatism, a Society is about to be formed for the purpose of erecting a crematory near the city.

Abroad the movement gains ground. It has made most progress in Italy, where the first effort at reviving this mode of disposing of the dead was made in Milan in 1876. This was followed by Lodi in 1877, and later by Cremona, Rome, Varese, and Spezia, and plans are being made for buildings at Florence, Pisa, Leghorn, and Turin. Nearly all the Italian cities of size have Cremation societies, and the number of bodies which have been subjected to cremation amounts probably to over a thousand.

In Germany a crematory has been in operation at Gotha since 1878, and over two hundred bodies have been burned there.

In England the movement—as might be expected from the character of the people—has advanced slowly. Cremation societies, however, are being formed there, and one if not more crematories have been erected. Legal difficulties are said to stand in the way of its advancement among the English.

We have adduced enough to show that cremation is gaining ground with astonishing rapidity, and its momentum increases with its spread. We presume among the profession there will be but one opinion as to its desirableness; it therefore behooves us to push it with our voice and influence, and thus to aid in advancing public health and sanitary progress by removing what has been without doubt the greatest source of the spread of infectious and epidemic diseases known since enlightened Rome and Greece burned the bodies of their dead.

Bursting of Kitchen Ranges.—The danger of kitchen explosions should ever be kept in mind by housekeepres at this

season of the year. During a very cold night, when the water has not been turned off in the cellar by a careless servant, and the range fire has been allowed to go out, the contents of the "water-back"—the chamber back of the grate, where the water is heated before pouring into the boiler—and of its connecting pipes, and even in exceptional cases of the boiler itself, become frozen. In the morning the cook comes down, and either through ignorance or thoughtlessness kindles a hot fire, without looking to see that all is right with the pipes. As a result the steam generated in the water-back and pipes, before the latter have time to thaw, accumulates with an enormous pressure, until finally the iron receptacle gives way with a loud report, the range is reduced to ruins, and perhaps the inmates of the kitchen may lose their lives. Householders should not trust these matters entirely to servants, but should see that they are properly informed in regard to the danger which they may incur, and the precautions to be taken in order to avoid it. They should see that the water is turned off, in the cellar, regularly every night, and that the spiggots communicating with the house pipes are left turned on. It is often not a lack of economy to keep the kitchen fire burning during the night. Should the pipes freeze in spite of due precautions, or in consequence of their neglect, a plumber should be summoned to rectify the difficulty before a fire in the range is ventured on.

Intra-Pulmonary Injections.—*Dr. Beverly Robinson*, writing of the "Utility to Patients Suffering from Pulmonary Phthisis of Intra-Pulmonary Injections,"(*N. Y. Med. Rec.*, Jan. 10) says: I esteem it be a real advance in the treatment of pulmonary consumption. We all know what treatment by the old method means for the vast number of unfortunate beings who crowd our city dispensaries and hospitals. With the three late methods presented to the profession, viz., super-alimentation, continuous dry inhalations, intra-pulmonary injections, many patients will yet be saved who, with cod-liver oil and the hypophosphites alone or added to other resources usually employed, would most certainly die. Nothing prevents us from using all previous means to help our phthisical sufferers, but I would also make a very urgent plea for those I have just mentioned.

Reviews, Books and Pamphlets.

A Text-Book of Hygiene. A Comprehensive Treatise on the Principles and Practice of Preventive Medicine from an American Standpoint. By Geo. H. Rohé, M. D., Professor of Hygiene, College of Physicians and Surgeons, Baltimore. Baltimore: Thomas & Evans. 1885. Pp. 324.

We welcome gladly the advent of another meritorious contribution to our medical literature from a member of the profession of Baltimore. Dr. Rohé is well known to many of our readers, and we take pleasure in recommending his book to their consideration, for we feel confident that much may be gleaned from its careful perusal. The author does not claim originality, but has aimed, rather, to give us a clear, concise and fairly complete review of the multiplicity of subjects demanding consideration in a work on hygiene. This he has accomplished, giving us, as the result, an extreme-interesting and instructive book.

To the student of medicine it will prove invaluable, and we deem it the best text-book for his use, not only on account of its being the most recent compilation extant, but also because the subject is treated from an American standpoint. To those who desire to refer to the extensive literature of the subject it will be of service as a trustworthy guide. In fact, it is a book that should have a place on the book-shelves of every practitioner, as it contains information on points which are every day presented to his attention, and to which it behooves him to give careful study. We heartily recommend the work to all those interested in preventive medicine.

BOOKS AND PAMPHLETS RECEIVED.

Sixth Annual Report of the State Board of Health of Illinois. With two Appendices: (a) Conspectus of the Medical Colleges of America. Revised to Dec. 20, 1884. (b) Official Register of Physicians and Midwives in Illinois. Revised to Dec. 1, 1884.

The Diagnosis and Treatment of Chronic Nasal Catarrh. Three Clinical Lectures Delivered at the College of Physicians and Surgeons, New York. By George Moorewood Lefferts, A. M., M. D., Professor of Laryngoscopy and Diseases of the Throat in the College of Physicians and Surgeons, New York. St. Louis: Lambert & Co. 1884.

Fourth Annual Report of the Secretary of the State Board of Health of West Virginia, (Preliminary). For the Year Ending December 31, 1884.

Biennial Message of Gov. Jacob B. Jackson to the Legislature of West Virginia Session of 1885.

Report for the Year 1883–4, *Presented by the Board of Managers of the Observatory to the President of Yale College.*

A Discussion of Some Questions Relating to Tonsillotomy, and Clinical Remarks Upon Deflections of the Nasal Septum. By W. H. Daly, M. D., of Pittsburgh, Pa. Reprint from *Medical and Surgical Reporter.*

Aphonia Due to Chronic Alcoholism. Paralysis of the Lateral Cricro-Arytenoids. By Ethelbeat Carroll Morgan, A. B., M. D., of Washington, D. C. Chicago: Review Printing Co. 1884.

Consumption: Its Nature, Causes, Prevention and Cure. By J. W. M. Kitchen, M. D. New York and London: G. P. Putnam's Sons. 1885. Pp. 223. Cushings & Bailey, Baltimore.

One Hundred Years of Publishing. 1785–1885. With the Compliments of Lea Brothers & Co.: Philadelphia. 1885.

Miscellany.

Treatment of Hæmorrhagic Malarial Fever.—*Dr. Thos. F. Wood* writes as follows on this subject in the *North Carolina Medical Journal* for December: Statistics indicate a preponderance of success from large doses of quinine. The danger of fatal termination is referable primarily to splenic engorgement and secondarily to renal congestion. As the cold stage of an intermittent merges into the hot stage, the spleen increases largely in volume, greatly contributing to the arterial pressure in the kidney and causing rupture of the blood vessels of the glomeruli. The object of all treatment is prevention of return of fever. Owing to irregularity of return the administration of quinine cannot be timed with exactness. Cinchonism must be prompt and profound. Owing to the gastric irritability—a common concomitant of the febrile stage—and limited ability of the stomach to absorb, stomach administration is seldom successful. Hypodermic injections offer a highly valuable medium for the introduction of the drug. No solvent, however, whether citric, tartaric, hydrobromic, sulphuric or oleic acid obviates the liability to serious abscesses. This method can be trusted as long as the circulation is active.

It is necessary to make enough punctures to introduce a drachm or more of quinine, as it is unwise to force into one enough solvent to carry a drachm, because bad sloughing will result, as the author has had several times to regret. The abdomen and thighs are good points for puncture. Quinine might also be applied to a blistered surface, use being made of the vesication to relieve the irritable stomach, (ten grains every three hours, annointing the parts well with lard) or large capsules might be introduced into the rectum, irritability of the bowels not being a usual accompaniment of the disease—only intense cinchonism can be relied upon; Dr. Wood's rule is to keep up such a degree of this, in acute cases, that the patient can just perceive the ticking of a watch at one inch. Although the author has not seen any bad results from the use of morphia hypodermatically, but rather good in quieting the stomach and intensifying the action of the quinine, he yet disapproves of it on theoretical grounds as interfering with the removal of the accumulated effete material through the kidneys. To relieve irritability of stomach and inactive bowels, and to give increased breathing space by relieving engorged viscera, no medicine is more satisfactory than calomel, gr. v to vi, with bicarbonate of soda, gr. x to xv, repeated in six hours if necessary. A little experience with calomel in the early hours of hæmorrhagic fever will bring forcibly to mind the confidence which the older generation of doctors had and still have in it. The author's observations have not been favorable to the use of ergot although he would not condemn it without further trial. Dry heat, by hot blankets and hot bottles, is of prime importance to prevent fatal depression; the free use of crushed ice enables the patient to bear better the irksomeness of this measure. He has seen no good from alcoholics, but hot water with carbonate of ammonia is a good stimulant and well borne. The recumbent position must be maintained as there is danger from heart-failure. The

catheter should be used twice daily. During convalescence a ferruginous tonic with arsenic and nux vomica are required. A change of air is very desirable. Owing to danger of recurrence, which is always more dangerous than the first attack, recovery must be complete before the patient incurs again the risks of malarial influences. Prevention is to be secured by taking in hand the first chill and applying the one safe and sure remedy—quinine.

Introspective Insanity.—Among those vague conditions of mental weakness in which there is slight derangement of the intellectual powers, yet a decidedly marked enfeeblement of the will, and an excitement of the emotions of a more or less limited kind, we find a variety of interesting psychoses which have, within a comparatively recent period, been considered under the names *folie du doute* or *grübelsucht*. And in an interesting clinical paper in *The American Journal of the Medical Sciences* for January. Dr. Allan McLane Hamilton treats them under the title of "introspective insanity." In the cases of Dr. Hamilton relates there was a history of insanity, and the nervous temperament was manifested by various peculiarities, more often by a species of hypochondriasis,, by peculiarities of temper, and by acts of eccentricity which caused the subjects to be looked upon as "queer." These terms are applied to the condition of mind which is manifested by a morbid feeling of doubt and consequent indecision under the most ordinary circumstances, when both the doubt and indecision are unreasonable in the extreme, but the individual under the mandate of an imperative conception yields more or less to his disordered emotions. Some years ago we would speak of this condition of mind as "hysteria," or, if it influenced the patient's conduct to any remarkable degree, we would be at a loss for a proper explanation.

Pneumonia.*—This report, which has been drawn up by Dr. Octavius Sturges and Dr. Sidney Coupland, deals with a total of 1,065 cases, of which 192 proved fatal. The exact proportion of males and females cannot be given because some of the observers omitted to mention the sex in their reports, but 704 were known to have been males and 356 females, the proportion of males to females being thus as nearly as possible as two to one. As regards habits, of 655 returned as temperate 114 died or 17·4 per cent.; of 267 returned as total abstainers 28 died or 10·4 per cent.; whilst of 105 returned as intemperate there died 45 or 42·8 per cent. As regards food, of 988 stated to have had sufficient food 175 died or 17·7 per cent.; whilst of 60 said to have had insufficient food 15 died or 25 per cent. The coincidence of other diseases in the same house at the same time with a case of pneumonia was rare; as the reporters say, no disease occurs in the same house with pneumonia so frequently as pneumonia itself; the only diseases at all apt to be present were found to be bronchitis and tonsillitis. As regards a family history of lung disease, phthisis was met with in from 17 to 18 per cent. of the cases. It is quite exceptional, the report says, to find subjects of pneumonia who are of phthisical family exhibiting apex pneumonia. In the few instances where this actually happened, the seat of disease, judged by its course and termination, did not display any phthisical character. Enquiry into the previous diseases of the patients did not reveal anything of importance except the frequency of previous attacks of pneumonia. Out of 967 in whom the point was ascertained, 101 had suffered from pneumonia previously, and of these 19 died; only 16 persons were returned as having had more than two attacks of pneumonia, of these 4 died. The presence of a rigor at the commencement of the disease was noted in 782 cases, and its absence in 193, the point not being determined in 90; a further enquiry as to its relative frequency according to the part of the lung affected showed that in apex pneumonia a rigor was present three times out of four, and in basic pneumonia four times out of five. The right lung was affected more often than the left and the left more often than the two together, the right base being by far the most common seat of the disease, and next in order of frequency the left base. The crisis occurred most frequently on the seventh day, and with equal frequency on the sixth and eighth days, it occurred on the fifth day rather more frequently than on the sixth or eighth day, and twice as often as on the

* Report of the Committee on Pneumonia. The Collective Investigation Record, Vol. II, 1884.

ninth day. It took place on the fourth day more often than on the ninth; and on the ninth more often than on the tenth. From the eleventh to the fourteenth day subsidence by crisis was extremely rare. Gradual subsidence was more common than sudden in the proportion of about four to three, the latter being especially seen in cases of apex pneumonia. Of the 175 deaths in which information as to the day of the disease was given, 70 died on the sixth, seventh or eighth days. Amongst the general conclusions of the reporters we note in reference to sanitary conditions, first that defective house drainage and sewer-gas poisoning may both cause and favor the spread of pneumonia, and secondly that the affection when of this origin is not of exceptional severity or high mortality. Alcoholic excess is stated to be not only an important factor in determining the issue of pneumonia, but is often of itself the actual exciting cause of the affection. Fatigue and mental emotion rank next to alcoholic poisoning as the most unfavorable vital conditions wherewith to meet it. As to the infectious character of pneumonia they think that it may exist under certain insanitary conditions including thereby deficient ventilation, but they state at the same time that pneumonia as commonly seen has no infectious character. They do not find that there is such a thing as an inherited tendency to pneumonia, or that there is any other form of lung disease to be met with in excess in the direct family history of the patients. As to the seat of the disease they say that the apex is as favorable for the patient as any other, that no tendency is observable on the part of patients of phthisical family to exhibit pneumonia at that seat, and that in the exceptional event of pneumonia occurring in a patient of phthisical family, such pneumonia shows no tendency to degenerate into phthisis, but undergoes resolution as quickly and as completely as another. They conclude their report with the following statement:—(1) Of pneumonia as a local affection there are examples in plenty, especially in early life. Its onset is sudden, and due to some notable chill or exposure of the body; it has all the characters of acute inflammation with a marked tendency to spontaneous recovery, and is largely dependent on certain meteorological conditions which are productive also of other forms of lung inflammation. (2) Distinguished from these are examples of secondary pneumonias which arise in the course of many acute and specific affections and which do not at present concern us. (3) In addition to these two well recognized forms of the disease, clinical observation, we think, bids us recognize a third variety—a pneumonia due to causes not directly injurious to the lung, but operating through the blood or nervous system. It too is properly a secondary pneumonia, for it is but the signal and expression of anterior vital changes; yet owing to the absence (or the apparent absence) of any other organic lesion, it is not so accounted. Although anatomically indistinguishable (so far as we know at present) it deserves separate recognition in virtue as well of its distinctive origin as of the fact that it has a variable rate of mortality, and a gravity which is not commensurate with the extent of lung tissue involved.—*Med. Times and Gaz.*

Lancing Children's Gums.—In the discussion of this subject before the Medical Society of London, Nov. 3rd, (*Brit. Med. Journ.*, Nov. 8) *Mr. Hamilton Cartwright* (dentist) was distinctly of opinion that both diarrhœa and convulsions might be caused by dentition. There were two conditions under which lancing the gums is indicated: 1. If the gum is tense and glistening at the epoch when the tooth is about to come forward, by cutting into the sac of the tooth great and immediate relief is afforded. 2. In an inflammatory condition of the gums with tumidity, but without the extreme tension of the first class of cases, incision gives relief. In the latter class of cases the treatment is empirical but none the less successful.

Dr. C. J. Hare said it was to him a matter of great surprise and regret that the profession should so blindly give way to fashion as it had done on many points. Hundreds of lives had been lost by abandoning the use of bleeding; and among the forms of bleeding, the practice of lancing the gums, that is, bleeding from the gums, is one that deserves to be revived or continued. *Dr. Webb* had seen so many children on the point of death saved by lancing the gums that he regards it as a most valuable method of treatment.

Iodoform Collodion.—An iodoform collodion is well spoken of for wounds in an

exposed situation. It consists of iodoform 10 parts, and collodion 90 parts. To be applied with a camel's hair pencil, the edges of the wound being held together until it dries.

(*Special Notice.*)

SEVEN SPRINGS IRON-ALUM MASS.—This excellent remedy meets with almost universal favor wherever it has been used. Of its efficiency and usefulness in the treatment of a certain class of complaints, there can be no doubt. Being endorsed by many of the most eminent physicians of Virginia, and elsewhere, is a sufficient guarantee of merit. Every physian knows something of the difficulties referred to, in the advertisement on page 13, and as there is no lack of such patients within the range of practice, we bespeak for the "Iron-Alum Mass" a wide field for operation, and hope the profession generally will give it their attention.

Medical Items.

Dr. J. M. Dacosta was elected President of the Philadelphia College of Physicians on the 7th instant.

Dr. Ambrose L. Renney, Professor of Applied Anatomy in the Post-Graduate Medical School of New York city, has been appointed to fill the Chair of Anatomy in the University of New York, rendered vacant by the death of Prof. Wm. Darling. Dr. Ranney has also been elected to the lectureship on Anatomy in the University of Vermont, formerly held by Dr. Darling.

Hereafter in the Austrian hospitals all the preventions used in infectious diseases will be applied to phthisis, including isolation and prophylaxis.

Centralization in the Hospitals seems to be the order of the day. There is an evident inclination of medical men to devote themselves to one service, and through resignations, the staff at some of the hospitals—the New York and Roosevelt especially—are greatly reduced in number. At the latter all the surgery is in the hands of Dr. Sands and an assistant.—*Medical News.*

Carbolic acid in a five per cent. solution destroys the bacilli in phthisical sputa.

Dr. Steinberg recommends liquor sodæ chlorinatæ as an efficient germicide.

According to the *Record* of January 17th, the amount of the Hospital Saturday and Sunday collection in New York is $22,655.53.

In the University of Nebraska there are 9 regular professors and 3 regular lecturers, 3 homœopathic, and 3 eclectic professors.

A recent incident at the New York Hospital illustrates the value of the trained nurse. A patient, whose innominate artery had been tied by Dr. Bull. had hæmorrhage from the proximal end of the artery on the thirtieth day. The first gush of blood was tremendous. The nurse, Mrs. Schaefer, promptly tore off the dressings, and, thrusting one finger into the wound, which was quite narrow, arrested the bleeding instantly. Not a drop of blood was lost after this until two hours later, at which time the nurse's finger was replaced by a firm tampon of iodoform gauze, when a trifling hæmorrhage occurred at the moment the change was made. The patient died on the thirty-second day.—*New York Med. Journal.*

Odd expressions are sometimes made by authors. In the last New York *Medical Record* a physician mentions that "Dr. Osio lost three eyes by panophthalmitis." Three-eyed medical gentlemen are so scarce in this world that the doctor's mishap takes on the proportion of a public calamity.—*Evening Post.*

According to official reports there were 17,300 cases of cholera in Italy during the recent epidemic, with 8,600 deaths, giving a mortality of about 50 per cent. This hardly sustains the view advanced by some that cholera is becoming less malignant.

The College of Physicians of Philadelphia, at the recent annual meeting, elected the following-named gentlemen to office for for this year: Dr. J. M. Da Costa, President; Dr. S. Wier Mitchell, Vice-President; Dr. Richard A. Cleemann, Secretary; Dr. Charles Stewart Wurts, Treasurer; Dr. J. H. Hutchinson, Honorary Librarian; and Dr. J. Ewing Mears, Recorder.

Dr. Edward N. Brush, of the Utica Asylum, formerly of Buffalo, has been appointed to the charge of the male department of the Pennsylvania Hospital for the Insane.

The American Neurological Association meets in New York, June 17th.

The first essential in the intelligent use of the pessary, and for the avoidance of its abuse, is a correct diagnosis; and the second is an understanding of its action. Without these nothing but confusion, and probably injury, can follow.—*Bantock.*

Bromide of ammonia is recommended by Da Costa in the treatment of acute inflammatory rheumatism. It diminishes the tendency to heart complications.

Bartholow uses hypodermics of ether to tide over the crisis in typhoid pneumonia.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, from Jan. 30, 1885, to Jan. 26, 1885.

Tremaine, W. S., Major and Surgeon, granted leave of absence for one year on surgeon's certificate of disability.

Mans, Louis M., Captain and Assistant Surgeon, granted leave of absence for two months on surgeon's certificate of disability, with permission to leave the Division of the Missouri.

Stephenson, Wm., First Lieutenant and Assistant Surgeon, relieved from duty at Fort Omaha, Nebraska, and ordered to Fort Niobrara, Neb., for duty.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE UNITED STATES MARINE HOSPITAL SERVICE from October 1, 1884, to December 31, 1884.

Bailhache, P. H., Surgeon, granted leave of absence for thirty days, Oct. 9, 1884, to proceed to Wilmington, N. C., as Inspector, Nov. 10, 1884. Relieved from duty as Chief of Purveying Division, to proceed to Philadelphia, Pa., and assume charge of the Service, Dec. 10, 1884.

Wyman, Walter, Surgeon, granted leave of absence for fifteen days, Oct. 15, 1884. Leave of absence for fifteen days in December, 1884, and thirty days in January, 1885; also for a further period from January 31, 1885, without pay, and with permission to visit Europe, Dec. 8, 1884.

Purviance, George, Surgeon, when relieved to proceed to Cincinnati, Ohio, and assume charge Nov. 12, 1884. To Louisville, Ky., as Inspector, Nov. 24, 1884.

Austin, H. W., Surgeon, to proceed to Boston, Mass., and assume charge, Nov. 12 1884.

Smith, Henry, Surgeon, when relieved to proceed to Cairo, Ill., and assume charge, Nov. 9, 1884. Granted leave of absence until January 15, 1885, Dec. 17, 1884.

Stoner, G. W., Passed Assistant Surgeon, relieved from duty at Delaware Breakwater Quarantine, to proceed to Cairo, Ill., in accordance with former orders, Oct. 14, 1884. To Norfolk, Va., Nov. 19, 1884.

Irwin, Fairfax, Passed Assistant Surgeon. To close Cape Charles Quarantine October 31, 1884, proceed to Washington, and report to Surgeon-General, Oct. 14, 1884. To take charge of the service, port of Georgetown, D. C., and detailed as Acting Chief Clerk, Surgeon-Geheral's Office, October 30, 1884. To Philadelphia, Pa., and Baltimore, Md., as Inspector, December 30, 1884.

Mead, F. W., Passed Assistant Surgeon. When relieved to proceed to Baltimore, Md., and assume temporary charge. Dec. 10, 1884.

Heath, W. H., Passed Assistant Surgeon, Granted leave of absence for thirty days on account of sickness. Oct. 24, 1884.

Guiteras, John, Passed Assistant Surgeon. To report to Surgeon-General. Nov. 8, 1884. Leave of absence extended fifteen days without pay. Nov. 14, 1884.

Wheeler, W. A., Passed Assistant Surgeon. Relieved at Chicago, Ill.; to proceed to Buffalo, N. Y., and assume charge. Dec. 26, 1884.

Banks, C. E., Passed Assistant Surgeon. When relieved detailed for special duty; upon completion of same, to Boston, Mass., for duty. Oct. 28, 1884.

Peckham, C. T., Passed Assistant Surgeon, granted leave of absence for twenty days, Dec. 26, 1884.

Bennett, P. H., Assistant Surgeon, when relieved to rejoin his station, (Detroit) Nov. 20, 1884.

Ames, R. P. M., Assistant Surgeon, to report to Surgeon Hutton, at Louisville, Ky., for examination for promotion. Nov. 13, 1884.

Devan, S. C., Assistant Surgeon. To proceed to Tacoma, W. T., as Inspector, Oct. 14, 1884.

Kalloch, P. C., Assistant Surgeon, granted leave of absence for thirty days. Nov. 19, 1884.

To be continued.

Original Articles.

NOTES ON SOME INSTRUCTIVE CASES OF HERNIA.*

BY JOHN B. ROBERTS, M.D., OF PHILADELPHIA.

Hernia is a condition often seen and often improperly treated; therefore, I shall not apologize for bringing a few illustrative cases to the attention of the Society, in the hope of stimulating discussion on this important topic.

REDUCTION OF AN IRREDUCIBLE FEMORAL HERNIA OF SEVEN YEARS' STANDING.

Some months ago a woman was sent to me by a medical friend in a neighboring State, suffering with a small, painful tumor in the right groin, which had appeared seven years previously, while she was lifting a heavy weight. The tumor had never been "pushed back," and had of late increased somewhat in size. For its treatment she had recently bought a truss, but could not wear it. When seen by me the hernia was the size of a small hen's egg, was somewhat painful when handled, and occupied the situation of the femoral ring. The truss she brought with her was one for inguinal hernia, and gave pain by pressing on the tumor. After reduction of the hernia was accomplished I found, as was to be expected, that the truss pad did not cover the opening through which the hernia escaped.

I placed her in the recumbent position, in my office and without difficulty succeeded in reducing the entire hernial protrusion by first pulling the tumor downward, in a direction toward the knee, and then pushing backward, toward the bed. No anæsthesia was employed. A truss made with an inguinal hernia pad and a band passing around the perineum from the pad to the back of the truss spring seemed to retain the intestine securely within the abdomen. As the patient has not applied for further treatment I presume that she has had no special inconvenience since.

It certainly is strange that a hernia which had never been returned since its appearance seven years previously should be so readily reduced. Attempts to reduce it had, according to her statement, been previously made, but I know not how often. After I replaced the gut, which I did several times during her stay in the city, I could put the tip of my finger into the femoral ring, thus showing that the reduction was complete. I am inclined to believe that she had a small, direct inguinal hernia in addition to the femoral hernia, for, after reducing the femoral hernia, which caused the main bulk of the tumor, a small tumefaction was still left, which could be made to disappear by pressure toward the external inguinal ring. On the other hand, I thought I was able to push back this upper part of the mass and hold my finger in the inguinal ring, without affecting the femoral hernia which certainly existed below.

This occurrence of double hernia on the same side is often, I think, overlooked in hurried examinations.

IRREDUCIBLE INCOMPLETE HERNIA.

A man of 77 years, who had a reducible hernia of the right side, sent for surgical aid because he noticed a small swelling in the left groin which he could not reduce. He told me that he formerly had left-side hernia, but had been cured by wearing a truss. He was anxious, because the right hernia had once become strangulated and required manipulation by a physican to reduce it. I saw him late in the afternoon. He lay in bed, with slight abdominal uneasiness, but had had no vomiting, and during the day had had an evacuation of the bowels. The abdominal wall was thin, and above Poupart's ligament on the left side I could feel within the wall a tumor the size of a small black walnut. On coughing, distinct succussion was felt in the tumor, which protruded little or none through the external inguinal ring. The tumor, which was tympanitic, was evidently an oblique inguinal hernia, which had not traversed the entire length of the inguinal canal.

Under ether I attempted taxis, but, though I heard some gurgling in the belly during my manipulations, I felt no distinct slipping of the hernia into the abdominal cavity. The tumor, however, seemed smaller, and by invaginating the scrotum I could introduce my finger half way up the inguinal canal. I concluded that he had previously had a small, incomplete hernia, which had passed unnoticed; and that a sudden in-

* Read before the Philadelphia Clinical Society Dec. 26, 1884.

crease, with some attending pain, had called his attention to the groin on this occasion.

Accordingly, I prescribed a little morphia and recommended quiet in bed. When I visited him next day the tumor was entirely gone; and he reported that, shortly after his recovery from ether, pressure by his own fingers easily caused the protrusion to disappear. Some tenderness still remained. He was told to stay in bed two days and then obtain a truss. I have not seen him since.

RECOVERY FROM STRANGULATED HERNIA AFTER REFUSAL OF OPERATION.

Two or three years ago Dr. J. C. DaCosta requested me to see a man who had had left-side hernia about four years, which was now, and had been for many months, irreducible. For two days and a half the patient had had no stool and had been complaining of pain referable to the hernial and to the umbilical region. Dr. DaCosta had attempted taxis, but failing, had given castor oil, which was vomited without inducing an action from the rectum. An enema was ordered and a subcutaneous injection of morphia given; after which he called me to meet him in consultation. When we saw the patient he complained of no pain. I was not able to get any accurate history of the case from the man himself or his family, but he had a hernia the size of a black walnut, elongated horizontally, lying apparently below Poupart's ligament. I was unable to determine to my satisfaction whether it was direct inguinal or a femoral hernia. Taxis under ether failed to reduce the hernia, and as herniotomy, though strongly urged by Dr. DaCosta and myself, was refused, opium and belladonna were administered and ice applied to the tumor.

I did not see the patient again, but was informed, two days later, that abdominal tenderness was somewhat more marked, though there was no pain except on pressure. No action of the bowels had occurred. When I saw the attending physician several weeks after, he said the patient had recovered without showing any further unfavorable symptoms. The hernial tumor, of course, remained.

In this instance the unfavorable prognosis made by me was unsustained by the history of the case. Whether strangulation of a small portion of an old hernia was relieved by the manipulative efforts made by Dr. DaCosta before my visit, or by our joint action, or whether actual strangulation never existed, I was unable to determine. The history, indefinite as it was, and the symptoms, justified resort to operation, because of the well-known danger of operative delay in strangulated hernia. In all similar cases I should still advocate exploratory incision.

HERNIOTOMY FOR STRANGULATED FEMORAL HERNIA IN A PARALYTIC.

A feeble woman, aged about 60 years, and almost helpless from cerebro-spinal sclerosis, had had for many years hernia in both groins, and wore a truss. The daughter, who had to feed the patient and wait upon her, on account of her paralytic condition, was able to reduce the hernial protrusions when they appeared. On August 18th, 1882, at 9 A. M., the hernia at the right femoral ring became irreducible after protrusion. The bowels were opened during the day and there was nausea but no vomiting. She seemed, when seen in the evening, to have considerable abdominal pain, but her mental condition and inability to articulate plainly made the obtaining of an accurate history difficult. The tumor, which was the size of a very small apple, was firmly fixed and could not be reduced. After futile efforts at reduction, under ether, I made, about eleven hours after strangulation, an incision, and tore through the coverings with forceps and fingers until I reached the sac. Then I stretched Gimbernat's ligament by forcing my finger tip into the canal, but the hernia was still irreducible, showing that the constriction was probably in the neck of the sac. After sweeping my finger arouud the neck of the sac and detaching it from the surrounding tissues, I was able to overcome the obstruction to replacement, and easily pushed the gut into the abdominal cavity. The sac was, as is seen, not opened. I believe that I stretched or pulled apart some pleatings or folds at the neck of the sac, and thus liberated the intestine. After pushing the sac also back into the abdomen, the wound was washed with carbolized water and sutures applied. One of the sutures was a very deep one. No ligatures were needed. The wound healed promptly, with but a single drop of pus. The patient's return to

her usual condition was delayed, however, by the occurrence of troublesome diarrhœa.

About eighteen months afterward I saw her. There was then a small hernia at the old site, for which she wore a truss. On the left side I found that the hernial tumor then existing consisted of a large inguinal and a small femoral protrusion. She wore a truss for this tumor, but it did not retain the intestine within the abdomen; but her inability to walk, because of her paralytic state, rendered the wearing of a truss not so essential as in an active person.

I might report other cases of hernia in which I have seen more or less unusual features; for example, a case of herniotomy in a child of six weeks, which I recently saw in consultation with Dr. Steinbach, who operated; or that of a woman with exceedingly large inguinal hernia; but for my purpose of exciting discussion the cases reported will be sufficient.

I desire to emphasize the following points:—

That inguinal and femoral hernia will be found at the same time on the same side much oftener than is supposed.

That it is safer to operate in cases of suspected strangulation than to postpone operation beyond twelve hours.

That herniotomy is attended with little hemorrhage, and if done antiseptically, is accompanied by rapid union and little risk to life.

A CASE OF POISONING FROM THIRTY GRAINS OF CHLORAL HYDRATE.*

BY JOSEPH B. POTSDAMER, A. M., M. D.

As dangerous symptoms rarely arise from the administration of thirty grains of chloral hydrate, I deem the notes of the following case of sufficient importance to bring them to your attention this evening:

J. R., æt. 43, in moderately fair health, has for the last three years been a victim of insomnia, caused by business troubles. For the relief of the sleeplessness, he used the bromide of potassium, until marked bromism was produced, and he was advised by a physician to discontinue it. This was about a year ago. He then began to take chloral hydrate. He would buy ten cents' worth of the drug, which, I am informed by several druggists, would be a drachm. This quantity he would divide into four doses, and take one about once in ten days or two weeks as occasion would demand. On or about the fifth of October, he bought at a drug store a drachm of Schering's chloral hydrate dissolved in a half ounce of water, which was labeled "teaspoonful at a dose." On retiring that night he took half of the above-mentioned solution, that is, two drachms containing thirty grains of the drug. This, he said, had very little effect upon him.

On the sixteenth of the same month he retired at about 8 P. M., taking the remaining portion of the solution, that is, the other thirty grains. About 11 P. M. his wife found him in a profound sleep, and, as there was a rattling of mucus in his throat, became alarmed and sent for me. I reached the patient's bedside soon after. Having been informed of the circumstances of the case, I at once proceeded to examine the patient, and found him in the following condition: Thoroughly unconscious; pupils contracted; respirations, shallow and slow, about eight per minute; breathing stertorous; fauces full of mucus, giving rise to the rattling; pulse barely perceptible, was unable to count it; heart sounds weak but regular; extreme coldness of face and extremities.

Having understood the family to say the drug had just been taken, I administered twenty grains of the sulphate of zinc in a glass of water, at 11.45 P. M.; applied cold flagellations to the body, and gave strong coffee and whisky. October 17, 12.15 P. M., patient not having vomited, gave twenty grains of powdered ipecac in a large quantity of hot water; continued the coffee and and made efforts to rouse the patient; at 12.45 P. M. the emetics operated; this was followed by temporary dilatation of the pupils; 3 P. M. able to rouse the patient; pupils react slightly to light; 6 A. M., patient, on being aroused, talks rationally, but drops off to sleep again; pulse perceptible, one hundred beats per minute; respirations normal, eighteen per minute; 1 P. M., patient sat up for a little while; still very drowsy; 8 P. M., he has been awake since 5 P. M.; complains of headache. October 19, 10 A. M., has had a good night's rest, and feels perfectly well. The treatment previously described, excluding the emetics, was continued throughout the night.

* Read before the Philadelphia County Medical Society, December 17th, 1884.

For a week prior to taking the last dose of chloral, the patient's appetite had been poor, and he ate very little. He was somewhat reduced in strength, this may perhaps explain the action of the drug.

1629 N. Eighth St.

Clinical Notes.

POWDERED ARECA NUT IN THE TREATMENT OF TAPE-WORM.

Dr. Genese, of Baltimore, writes:

In the article upon treatment of tape-worm noticed in your Journal of November 15th, I find a number of remedies mentioned, most of them being very unpleasant to administer, and not always to be relied upon. There is one drug for the treatment of worms in any form, either in the human or animal, that I have never known to fail, *i. e.*, the powdered areca nut, given in from three to ten grains doses, in milk, in the early morning fasting. Care is necessary in regulating the dose, as severe gastritis may result from too large a one. While a three grain dose for a child may be repeated in half an hour if the worm is not expelled, a five grain dose to an adult will sometimes cause the expulsion within five minutes, and it leaves no after effects. I have known a five grain dose given to a terrier dog to cause gastritis to such an extent that it was swelled out of all recognition, but this is the only case out of a large number in which I have seen any ill effects from the drug.

A CASE OF DISLOCATED PATELLA WITHOUT RUPTURE OF LIGAMENT.

Dr. J. C. Butler, of Belair, Md., writes:

On December 18th, Patrick L. came under my care in the Alms House; having this history: The day before was caught in the rigging of a boat, and fell with great force, causing an *incomplete* external dislocation of right patella. This was immediately reduced and a temporary bandage put on by Dr. Smith. I saw the man the next day and found all parts "in statu quo," and the patient easy, so did not disturb the limb. On the night of the 20th, on account of great swelling and pain, he removed the bandage, and was very restless. The next morning I found a *complete* dislocation; the patella had so slipped that the under edge of the bone was on a line with the external condyle of the femur. It was again reduced, and the time-honored pasteboard splint was applied, and with the use of cooling applications the swelling subsided and he has done well. I report this case not as a rarity, but as one not usually met with.

Society Reports.

PHILADELPHIA CLINICAL SOCIETY.

STATED MEETING HELD DECEMBER 26TH, 1884.

Dr. Henry Beates in the Chair.

Dr. Jas. B. Walker reported a case of

ULCER OF THE STOMACH,

which came under his observation at the clinic of the Woman's Hospital, January 13th, 1881, suffering from a *third* attack. The first had occurred three years before, and was accompanied by hæmatemesis. After an interval of about a year and a half, a recurrence of all the symptoms, except the hæmatemesis, brought her to the clinic, where gastric ulcer was diagnosticated, and she rapidly recovered under treatment. The third attack, the one under consideration, had existed nearly two months before she applied at the same clinic for relief. She was in a condition of profound emaciation and exhaustion, presenting a cachexia suggestive of malignant disease. The previous history aided in the exclusion of malignancy, and on account of the serious condition of the patient, and the necessity for more than ordinary care, she was admitted into the wards of the hospital.

At first all foods gave intense pain, even in minimal quantity, and water administered in teaspoonful doses was immediately rejected. All feeding by mouth was suspended and enemata of beef tea were alone administered. For twenty-three days, not a particle of food was given in any other way. Then milk in minute quantities was tentatively administered in alternation with minute doses of beef tea, and after three or four days, the stomach proving able to perform its functions without pain or uneasiness, the enemata were discontinued and the patient discharged, her health being completely restored. The

medicinal treatment consisted in blistering the epigastrium; the admistration of large doses of subnitrate of bismuth at four hour's intervals during the day, and a quarter of a grain of nitrate of silver at bedtime. Inunctions of sweet almond oil were used towards the close.

The author spoke of the value of oil of turpentine in fifteen or twenty-drop doses, in sweetened water, at intervals of two hours, in cases of hemorrhage from ulcer of stomach, and mentioned one case in particular; it had apparently saved life, when all ordinary means had not only failed, but had seemed to aggravate the symptoms.

DISCUSSION.

Dr. A. V. Scott had used rectal alimentation in a similar case with success. Cinchonidia sulph. in twenty grain doses was given with the food.

Dr. E. E. Montgomery did not hear the whole report of the case, but was reminded by the concluding remarks of two cases seen during the previous year. The first was an old gentleman suffering from gastric catarrh and gastralgia—the latter appearing both before and after meals. Under rigid diet the pain after food ingestion was controlled, but that occurring in the empty condition was not lessened. Food was taken frequently. After several months of suffering the patient was carried off by an attack of pleuro-pneumonia. The post-mortem appearances indicated commencing carcinoma. The kidneys were not granular.

The other case was confined to bed six months with constant vomiting of food in a sour condition; food was rejected with equal impartiality. Dr. Bartholow being called in consultation found evidences of specific lesions, which had been denied by the patient. After using mercurials in vain, however, another consultation developed the suspicion that we had a case of hysterical vomiting to deal with, and, under appropriate treatment, the patient quickly recovered.

Dr. L. Brewer Hall desired to bear testimony of the value of turpentine in hemorrhage of the stomach. The good results of its use are immediate, and it is also of value in pulmonary hemorrhages. The oil of erigeron may be used instead and is more acceptable to the taste.

Dr. Henry Beates, Jr., asked Dr. Walker if he still looked upon the micaceous appearance of the skin as an evidence of carcinoma; and, if so, if it would not have been of service in the diagnosis of one of the cases related.

Dr. Walker, in closing the discussion, said he had seen but two cases with the micaceous skin, which were not carcinomatous, one being a case of pernicious anæmia. He looked upon it as only confirmatory. The use of oil of erigeron as a pleasant substitute for turpentine as a hæmostatic was suggested by the late Dr. Geo. B. Wood, but the accuracy of taste of the suggestor was doubted. The speaker had taken a dose of it on a patient's complaint several years ago, and had not recovered from it yet.

In the cases simulating gastric ulcer the resemblance is interesting. The dejectæ are more frequently sweet than acid in such cases. In unsuspected cases of carcinoma in plethoric subjects the peculiar appearance of the skin alluded to may be the only indication present of the real nature of the case.

As regards Dr. Scott's case the course pursued seemed to embody all that was necessary. Total rest of the affected organ is generally sufficient; then the bismuth may be useful.

DISCUSSION ON NOTES ON SOME INSTRUCTIVE CASES OF HERNIA.

(See this Number of JOURNAL, page 271).

Prof. Jas. B. Walker: In connection with Dr. Roberts' paper a brief narration of the salient points of the following cases may be of interest:

CASE I.—A lady, aged 79, as the result of a fall noticed a swelling in the left groin below Poupart's ligament, in vicinity of the femoral ring. The tumor soon occasioned marked disturbance. It was of doughy consistency, and cough failed to impart succussion. Percussion did not elicit a tympanitic note, and taxis failed to reduce it. As there was a doubt of its real nature anæsthesia was produced with ether, and still taxis failed. The existence of symptoms of strangulation, viz: constipation, nausea and vomiting determined operative procedures, when an entero-epiplocele was disclosed. The omental element was the greater, and enclosed a small knuckle of gangrenous intestine; this constituent of the tumor was so small that the ordinary

symptoms of succussion and tympany were rendered non-detectable. Hot water failed to develop manifestations of vitality, so the section of intestine was excised and the healthy ends stitched together. Suppression of urine followed the operation, and death resulted on the third day.

Case II was an instance of inguinal hernia in a female advanced in years. Efforts at reduction by a number of physicians had failed. Notwithstanding the length of time intervening, I, however, by properly applying taxis succeeded in reducing the tumor. The probable cause of failure on the part of other attendants was improper attempts at taxis. The mass pressed out over the ring in a manner to defeat their object. This is, in a majority of instances, the undoubted cause of failure of efforts at reduction.

Case III.—A male with eomplete right inguinal hernia—strangulated. Taxis failing an operation was resorted to, but the case terminated fatally. The peculiarity consisted in a deposit of fibrin or lymph nearly two inches in thickness surrounding the external ring.

Case IV.—A gentleman, whose vocation required at times heavy lifting, complained of a peculiar burning or stinging pain limited to the right inguinal region. There was no perceptible tumor. The symptoms were invariably aggravated by physical effort. I diagnosticated incipient inguinal hernia and advised a truss. The patient being dissatisfied, consulted an irregular physician who ridiculed the diagnosis given, and administered homœopathic powders for nearly four weeks with, of course, no result. By this time the hernia was protruded and unmistakable. The patient now wears a a proper truss and is practically well.

In reference to umbilical hernia I wish to call attention to the fact that the umbilical opening is comparable to the cranial fontanelles in that, like the latter, it gradually closes with advancing age. Basing my plan of treatment on this physiological fact I support the abdominal walls with a broad adhesive strip so applied as to approximate the umbilical region. To the umbilicus I adjust a compress *smaller* than the opening. This prevents protrusion without interfering with the closing process.

Dr. J. G. Heilman narrated the history of an aged colored man who suffered from an inguinal hernia which became strangulated. Anæsthesia with chloroform did not render reduction practicable. Dr. E. R. Stone and L. B. Hall were called in and, at the suggestion of the former, about a fluid ounce of a straw-colored fluid was evacuated from the sac by means of an ordinary hypodermatic needle. After this procedure the hernia was easily reduced, and a favorable result followed.

Dr. L. Brewer Hall directed attention to the high prices asked by instrument makers for trusses, and inquired if there was any way by which the poor could get them at more reasonable rates.

Dr. Walker in reply to Dr. Hall, explained how a ten dollar truss could be obtained from a Chesnut Street dealer, under such circumstances, for seven dollars.

Dr. Roberts, in closing the discussion, said: In my opinion the mortality in cases of hernia is due to two causes; first, too great an effort at taxis, whereby inflammatory changes are occasioned and surgical treatment complicated and endangered; second, delay. If *gentle* taxis fails herniotomy should promptly be performed. The conditions of delay and experimental manipulation by students at hospitals render hospital statistics of little value.

In one case of double hernia—*i. e.* in inguinal and femoral hernia on the *same side* I succeeded in maintaining them in place by an inguinal truss adapted so as to occlude both the external abdominal ring and the femoral ring. In umbilical hernia I apply a compress moulded of wax instead of the coin. It is more readily adapted to the size of the orifice and kept in close apposition.

According to the *Union Médicale*, there were 3,994 students registered on the 15th of October. On the 1st of December the number included 538 foreigners, among them 127 Americans, 96 Russians, 61 Roumanians, 52 Spaniards, 45 Turks, 30 Brazilians, 26 Swiss, 25 Greek, and 22 Englishmen. The number of lady students is 78, including 13 belonging to France, 47 from Russia, 11 from England, and 3 from America.

Dr. T. Gaillard Thomas regards the permanganate of potash recently introduced by Sydney Ringer as the best emmenagogue which has yet been discovered.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD JANUARY 8TH, 1885.

The President, DR. SHAKESPEARE, in the Chair.

Dr. E. O. Shakespeare presented

PRIMARY TUMOR OF THE LIVER IN A CHILD NINE MONTHS OLD;

AORTIC VALVULAR DISEASE WITH RUPTURE OF ONE OT THE LEAFLETS;

MALIGNANT TUMOR OF THE KIDNEY;

A LARGE RENAL CYST.

(The notes of the above cases have been withheld for future publication, and, in consequence, the interesting discussion upon them, in conjunction with the case of Dr. Longstreth, must also, for the present, remain unpublished).

SARCOMA OF THE CLAVICLE.

presented by *Dr. G. E. de Schweinitz.*

This specimen was sent to me by Dr. John Ashhurst for microscopical examination and he kindly gives me permission to exhibit it to-night. The tumor occurred in the person of a young girl, S. L. B., aged 16, who came to him for treatment last August. She was a somewhat frail-looking, clear-skinned blonde, whose general health up to the time of the appearance of the growth had been satisfactory. The family history was good, none of the other five children composing the family presented any similar affection, nor was there any history of tumor for two generations back. The tumor began at the left sterno-clavicular joint. As a small nut-shaped swelling, having arisen without known inflammatory or traumatic origin, although, as she further stated it was always believed that the patient had in some way, and unknown to herself, received an injury at this point. The growth of the tumor was rapid, and at the end of five months stood out as a prominent swelling, as large as an orange, occupying the inner two-thirds of the clavicle and was covered by somewhat reddened and thinned skin. Pain, although not constant, was at times a very severe symptom. On the 7th of last August Prof. Ashhurst removed the growth together with the inner two-thirds or three-fourths of the clavicle. Examination of the gross specimen shows it to be a spindle-shaped growth, about four inches long, three inches at its greatest breadth and two inches deep, which has taken its origin in the medullary cavity of the bone gradually and become surrounded by a firm fibrous or periosteous capsule. The true tumor tissue is of moderate consistence and of a reddish-brown color. Microscopic examination reveals the following points of interest: The capsule is composed of dense fibrous tissue from which prolongations pass, dividing the tumor into numerous spaces which are filled with small, round, sarcoma cells. These spaces are in many places again divided dy a delicate spindle-shaped tissue into small alveoli. In addition to the round cells, spindle-shaped cells are also seen in spots, giant-cells are absent, or at least only a few multinucleated cells, relegated to the regions of the spindle-cells are noted. The tumor, I think, should be classified as a small round-celled sarcoma, with an alveolar arrangement. If this tumor be accepted as a variety of alveolar sarcoma it is somewhat unusual. Twice, before this evening, specimens of alveolar sarcomata of the long bones have been exhibited to this Society, one of the femur by Dr. Nancrede and one of the knee-joint by Dr. Formad. At that time Dr. Formad thought the variety of the sarcoma justified a rather more favorable prognosis than usual, while Dr. S. W. Gross, during the discussion, after referring to the somewhat unusual microscopical character of the tumor, thought the outlook for the patient was bad, as this variety of sarcoma is particularly fatal. Dr. Formad's prognosis was correct, because in that instance the patient was alive and well, if I am not mistaken, for sometime after the operation, and may be now for ought I know. In regard to the result of the present case I am able to speak quite definitely. Although the operation was most successful and the removal of the growth quite complete, the hemorrhage insignificant and the recovery of the patient satisfactory, in about two months after the operation the trouble reappeared either in the old wound or about two ribs lower. In this case then, the truth of Dr. S. W. Gross's remarks has been only too thoroughly proven.

Dr. Shakespeare said that this specimen was of interest on account of the rarity with which similar ones had been presented

to this Society. Through the kindness of Dr. de Schweinitz he has had the opportunity of examining sections from the growth and thoroughly agreed with the exhibitor as to its nature.

Dr. Simes had also examined microscopic sections and entirely endorsed the statements made by the preceding speakers.

Dr. M. Longstreth presented

AN ALVEOLAR SARCOMA OF THE KIDNEY.

The patient, J. E., æt. nine months, was first under the care of Dr. McOscar—to whom I am indebted for the specimens and this history—suffering from an attack of summer complaint. The patient was at that time three months old, and had been ill for a week or two. He was in a state of great emaciation, and upon examination of the abdomen a swelling was found in the right flank. The little patient recovered from the bowel trouble, but the general condition did not materially improve. During the remaining six months of life the child was only occasionally under observation, and at those times suffered from paroxysms of pain apparently in connection with the tumor. The bulk of the tumor as felt through the abdominal wall did not seem to increase greatly up to his death. The urine was not carefully inspected. Three days before death the pain increased to great violence and in this condition death came. The post-mortem examination showed the enlarged right kidney more firmly adherent to the posterior abdominal wall, and to the ascending colon and mesentery as well as portions of the small intestine attached to its anterior surface. The diseased organ weighed fifty-two ounces, and presented itself as a rounded slightly oval mass, regular in outline, smooth of surface, and with a moderately firm elastic consistence. The capsular surface was of pretty dense shining whiteness, with conspicuous small vessels passing over it. On section, which measured 3½ inches by 3 inches in the two diameters, the tissue presented a very varied appearance. In parts it was of a dense white, perfectly homogeneous aspect; in others, the pinkish white mass showed streaks of yellow with numerous small spots of red, and there were also large blood-red areas. In other parts, the tissue was breaking down into cysts, of which several large ones were present, the largest of the size of an English walnut. The cysts were all situated on the periphery of the mass, but they did not cause any protrusion of the capsule. At the upper extremity of the mass, there was found a portion of kidney-tissue not invaded by the new formation. On section this portion occupied about half an inch of the long diameter of the mass, and was seen to be separated from the new growth by a thin partition of connective tissue; externally it showed itself like a lobule of kidney fitting like a cap on the spherical tumor, as does the supra-renal capsule on the kidney itself. The microscopical examination showed the new formation to be a small round-celled sarcoma. The greater portion of all sections presented cells nearly rounded in figure, imbedded in a perfectly homogeneous basic substance. The uniform area of cells was, however, interrupted by streaks of splindle cells, running in narrow bands, enclosing greater or less areas of round-cell tissue. These circumscribing bands of spindle-cells sometimes formed circular areas looking like the cross-section of a tube; in other places the bands pursued a very tortuous course, resembling the outline of a twisting, undulating tube cut in a longitudinal direction. The bands of spindle-cells were never of great breadth, rarely more than four or five splindles. The spindle-cells were not regularly or closely fitted, but were embedded like the round-cell elements, in a homogeneous basic substance. In the spindle-cell bands there were occasionally seen fine capillaries, filled with red-blood corpuscles, which sometimes ran along for a considerable length; many other capillaries were seen cut transversely or obliquely, also in the spindle-cell tissue. Many areas of hemorrhage were visible. In many places a scanty fibrillar tissue with variousshaped nuclei, oval, angular and spindle, was seen. This tissue was thrust in and filled the interstices between the areas of round cells, circumscribed by the spindle-cell tissue. Thus in the section one passed from areas of round cells to the narrow bands of circumscribing spindles, and then into fibrillar tissue, with open meshes apparently without any intercellular basic substance. The whole picture resembled the cortical portion of the kidney, transformed by the presence of a new growth; the lumen of the convoluted

tubes, greatly enlarged, were filled with a round-celled homogeneous basic substance tissue; the base-membrane of tubes transformed into spindle-cell bands, and finally areas of hyperplastic intertubular connective tissue, in which, or along the basement membrane of the tubes (spindle-cell bands), ran the intertubular capillaries. The left kidney weighed five ounces. On section it presented a normal aspect; the capsule separated easily, was not thickened, and the surface of the kidney remained smooth. The microscope showed no alteration of its tissues. The liver was large, smooth, blunt-edged, pale; under the microscope a very high degree of fatty infiltration was found. The other organs showed nothing especial to note. No secondary new formations were found.

A Method Proposed to Secure Children Against Attacks of Diphtheria.—Dr. F. Peyre Porcher: Acting upon the theory that diphtheria (whether or not it may depend upon a specific germ) is, at its inceptive stage, local, and has its seat in the fauces, which, if impressed or modified by suitable agents, will not offer a nidus for its reception, Professor Porcher proposes as a prophylactic the following: ℞. Tinct. ferri chlorid., 2 to 3 drachms; potassii chloratis, 2 to 3 drachms; quiniæ sulph., 15 to 20 grains; sodii hyposulphitis, 1 to 2 drachms; alcoholis 1 ounce; aquæ, 6 ounces. M. Sig.—A teaspoonful to a dessertspoonful three times a day in water. To be used by those who are exposed to the disease.

The author has used this formula for a number of years as a prophylactic for diphtheria in many families whose members had been exposed to the disease, and states that he has never known a case of diphtheria to occur where it was so employed.

Evidence is not wanting from other sources of the value of the medicines above named, especially the muriated tincture of iron and potassium chlorate, both as a prophylactic and cure for diphtheria.

The same formula is said to be serviceable in scarlet fever. And with two or three drachms of acid tartrate of potassium, in lieu of the hyposulphite of sodium, it has proved of great value in the treatment of erysipelas, ulcerative sore throat, cellulitis, and diseases of the lymphatic system. *Louisville Med. News.*

Editorial.

Hydrochlorate of Cocaine in Obstetrical and Gynecological Practice.—The remarkable results following the use of the hydrochlorate of cocaine in ophthalmic surgery have suggested the employment of this drug in a wide range of surgical conditions. Solutions of cocaine have been used in minor operations with varying degrees of success. It has been shown by numerous clinical facts that the sensibility of mucous and cutaneous surfaces may be entirely blunted by the application of solutions of two and four per cent. strength. The amount of insensibility is influenced by the strength of the solution and the number of applications. When employed topically, insensibility does not seem to extend into the subcutaneous or submucous tissues. This fact has limited its anæsthetic use chiefly to minor surgical operations. Solutions of the drug have been injected hypodermically into the deeper tissues with the effect of diminishing insensibility to a greater or less degree according to the nature of the tissues into which it was introduced. Abundant testimony is offered to show that the drug is not only a "boon" to the oculist, but that it will render valuable services to the surgeon in general practice, and to the obstetrician and gynecologist.

The use of cocaine in obstetrical practice has been chiefly limited to the vaginal mucous membrane during the second stage of labor. A number of reports have been made of its application to the vagina and vulva with the result of diminishing the sensibility of these parts and thereby lessening the tearing and lancinating pains occasioned by the passage of the child's head. It has been employed successfully during the operation for the restoration of the perineum immediately following labor. An aggravated case of vomiting of pregnancy due to an eroded cervix has been reported as relieved by the application of the cocaine to the eroded surface.

The writer has employed a four per cent. solution in a case of laceration of the perineum in which denudation of the surfaces of the wound was required preparatory to the closure of the perineal body. No pain was experienced during the pairing of the tissues, though some pain was experienced during the introduction of the sutures. The

patient bore the latter pain comparatively well.

The cocaine solution has been used in performing Emmet's operation, by several operators, with fairly good results. It was found necessary to make frequent applications during the passage of the needles through the deeper tissues. A case of vesico-vaginal fistula has been reported as having been performed after repeated paintings of the surface with a four per cent. solution.

Dujardin Beaumets has reported a case of vaginismus treated with cocaine with good effect. This authority pronounces, as the result of numerous observations, cocaine hydrochlorate to be the best therapeutic agent in this affection when due to inflammation and ulceration of the vulvar orifice. A case of exaggerated pruritus vulvæ, in which the usual remedies had failed, is reported as immediately relieved by the application of a four per cent. solution by Dr. Sarah J. McNutt, of New York City (N. Y. *Med. Record*, January 3d, 1885, p. 123).

In dysmenorrhœa a four per cent. solution applied to the cervical canal has been followed with marked relief.

The writer has had occasion to employ a four per cent. solution with marked benefit in the following condition: A patient with a very acutely retroflexed uterus of some years' standing suffered with great hyperæsthesia of the entire uterine canal. The simple introduction of the uterine sound occasioned great distress, and produced nervous manifestations of a most unpleasant character. It was extremely difficult to induce the patient to submit to local treatment. Attempts to replace the uterus by posture and manipulations with the finger were unavailing. A four per cent. solution was introduced into the uterine cavity, first by the use of the syringe, and afterwards by means of the applicator wrapped with absorbent cotton and saturated with the solution. With two applications of the solution, at intervals of ten minutes, the sensibility was so diminished that Emmet's elevator was introduced and the uterus restored to its proper axis without the patient's knowledge of the fact.

These results suggest a wide range of conditions in which cocaine may be successfully employed in obstetrical and gynecological work. The numerous cases of hyperæsthesia of the female generative organs, whether due to neurotic or inflammatory conditions, will most probably yield to the local application of the cocaine solution, and thus admit of the use of instruments and applications which were deemed impractical without anæsthesia. We would suggest its trial where pain and distress are occasioned in the examination and treatment of highly nervous and sensitive patients.

A Field for Statistical Investigation. The clinical records of our hospitals should be utilized to a much larger extent than they are at present. By being carefully studied from time to time they, without doubt, would yield very valuable statistical information, which, by throwing light upon faulty methods of treatment and imperfect hygienic regulations, would accomplish much toward the perfecting of the methods now in vogue.

The cleanly wards of a well-kept hospital, with its spotless walls, well-scrubbed floors and rows of tidy-looking beds, certainly do not present an unsanitary appearance, and yet, as the *Northwestern Lancet*, in a recent number, takes occasion to point out, in or around about the very beds themselves may lurk hidden and unsuspected sources of disease.

A hospital is spoken of where, during one year, three or four surgical cases which had successively occupied the same bed had had septic symptoms of some sort. It occurred to the house surgeon to look up the record of that bed for a series of years back, and he found, as a result of his investigations, that an unusual number of cases of septicæmia, erysipelas, etc., had originated there. It was then found that there was a defective sewer-pipe very near to the bed in question. The ward was temporarily vacated, cleansed, and the defect in the sewerage remedied. There has been no sepsis originating in the ward during the several years which have now relapsed.

Sir Andrew Clark has found that the corner beds in barrack rooms have a much higher sick-rate than others. His results are used as an argument in favor of circular wards.

It is suggested that the mortality of each bed for a number of years be looked up, together with the number of cases of septic disease originating in each.

The plan, we think, is a good one, as the subject is one in which statistical investigation would be of great value, and could be easily carried out in hospitals that have records. The investigation should not be confined to surgical wards, but an attempt should be made to discover whether typhoid fever, pneumonia, etc., do better in some beds than in others. The field is one in which the internes of hospitals may distinguish themselves.

Reviews, Books and Pamphlets.

Surgical Delusions and Follies. A Revision of the Address in Surgery, for 1884, of the Medical Society of the State of Pennsylvania. By JOHN B. ROBERTS, A.M., M.D., Prof. of Anatomy and Surgery in the Philadelphia Polyclinic, Surgeon to St. Mary's Hospital. P. Blackiston, Son & Co. 1884.

This little volume speaks for itself, and shows its author to belong to the race of bold, aggressive, practical surgeons of the present time. Prof. Roberts is perhaps a little too intolerant of other people's views in regard to chloroform as an anæsthetic, the indications for trephining and the use of chloral in tetanus; but the vigorous way in which he handles many of the most common "delusions and follies" prevalent among surgeons is very commendable. We would particularly commend to the general practitioner his remarks on the use of styptics, delay in incising phlegmonous inflammation, operations for malignant tumors, hernia, &c., and the inefficient administration of ether.

A System of Practical Medicine. By American Authors. Edited by William Pepper, M.D., LL.D., Provost and Professor of the Theory and Practice of Medicine and of Clinical Medicine in the University of Pennsylvania. Assisted by Louis Starr, M.D., Clinical Professor of Diseases of Children in the Hospital of the University of Pennsylvania. Volume I., Pathology and General Diseases. Philadelphia: Lea Brothers & Co., 1885. Pp. 1,094.

The present volume is the first of a series of books embracing "A System of Practical Medicine," by American authors. The series, when completed, will present a comprehensive work, undertaken by the co-operation of a considerable number of physicians of acknowledged authority. The design of the work is wide in its scope, and complete and exhaustive in its study of the various subjects of which it treats. The editor, Professor William Pepper, has called to his assistance a corps of the ablest medical practitioners and writers to be selected in America, and to each member of this corps has been assigned the preparation of one or more exhaustive papers on subjects in regard to which they were eminently informed and prepared to treat. The work, then, is the contribution of many pens, and represents a vast amount of talent and skill in its preparation.

The volume under consideration opens with the subject of General Pathology and Sanitary Science. Under this head is first considered General Morbid Processes, by Reginald H. Fitz, M.D. Ninety pages are devoted to this subject. The subject embraces a study of Inflammation; Thrombosis and Embolism; Effusions; Degenerations; Tuberculosis; Morbid Growths. General Etiology, Medical Diagnosis, and Prognosis is the title of the next subject considered, by Henry Hartshorne, M.D., LL.D. The subject of Hygiene is treated by John S. Billings, A.M., M.D., LL.D. (Edin.), and that of Drainage and Sewerage in their Hygienic Relations, by George E. Waring, Jr., M. Inst. C. E.

The second division of the volume is devoted to General Diseases. Under this head is first considered the subject of Fevers, beginning with Simple Continued Fevers, Typhoid Fever and Typhus Fever, from the pen of James H. Hutchinson, M.D., and closing with Relapsing Fever, by Wm. Pepper, M.D., LL.D. One hundred and thirty-eight pages are devoted to the above named subjects. Variola, Vaccinia, and no less than twenty-four other diseases, are next treated by different authors.

The discussion of the diseases is full and complete. Each subject is taken up systematically and disposed of after the manner usually employed by the authors of text-books. In fact the arrangement of the work is after the plan of a huge text-book on the Practice of Medicine, the only difference in resemblance being in the fact that the diseases are treated at greater length and in a more exhaustive manner, and each disease, with one or two exceptions, is written by a different author.

The advantage of such a work seems to us to reside in its comprehensive and exhaustive presentation of the various diseases considered, and in the special fitness of each writer for the task assigned him. No such work as this has ever before been given to the American profession. It is superior to Reynolds' System of Medicine, and to Zeimsen's work, from the fact that it presents the whole field of medicine as it is actually taught and practiced by its best representatives in America. It is a work which will represent a vast amount of experience and knowledge upon special subjects.

A Manual of Organic Materia Medica, Being a Guide to the Materia Medica of the Vegetable and Animal Kingdoms, for the use of Students, Druggists, Pharmacists and Physicians. By JOHN M. MAISH, Phar. D. Prof. of Materia Medica and Botany in Phil. College of Pharmacy. Second Edition. With two hundred and forty-two Illustrations. Philadelphia: Lea Brothers & Co., 1885. Pp. 511.

This work, in its first edition, has received marked favor from the pharmaceutical profession, no doubt because of the convenience of method and practical applicability which characterise it.

As it now appears, it is enlarged, to accord with the natural growth of the subject, as well as to accommodate several new features. Among the additions may be mentioned a description of the most important drugs indigenous to North America, and also, a list of remedies classified according to their zoological or botanical derivation. The latter will prove useful by facilitating reference to drugs of allied origin. The structural character of drugs has received increased attention, and a praiseworthy feature of the book is the universal excellency of its numerous wood-cuts, illustrative of the gross and minute structure of many of the most important drugs. This edition of the book, we think, will prove even more serviceable than its predecessor.

Insanity and Allied Neuroses, Practical and Clinical. By GEORGE H. SAVAGE, M.D., M.R.C.P., Physician and Superintendent of Bethel Royal Hospital, Joint Editor of "The Journal of Mental Science." With 19 Illustrations. Philadelphia: Henry C. Lea's Son & Co., 1884. Pp. 544.

A very readable and instructive little book, in which the author records his observations growing out of twelve years' experience in the treatment of insanity at the Bethel Royal Hospital.

Miscellany.

A CONTRIBUTION TO JACKSONIAN EPILEPSY AND THE SITUATION OF THE LEG CENTRE.—*Dr. William Osler*, of the University of Pennsylvania, records, in the January issue of *The American Journal of the Medical Sciences*, the history of an instructive case of Jacksonian epilepsy, the main points of difference between which and true epilepsy are, the slow onset, local in character, beginning in, or in mild attacks confined to, one limb or a single group of muscles; the gradual extension until the side is involved, or, in severe attacks, the entire body; loss of consciousness late, not early and sudden, as in true epilepsy; and, lastly, the muscular contractions are clonic.

His case lasted over fourteen years, the convulsions beginning in the left hand, at first monobrachial, then extending to the leg, afterwards becoming unilateral, and finally general; at first without loss of consciousness. For the first nine years of the illness, there were remarkable intermissions, lasting for six or seven months, once an entire year. Six years after the onset the left leg got weak and stiff. For four years, the tenth, eleventh, twelfth, and thirteenth of the illness, the seizures were frequent. During this period there were six weeks of unconsciousness in which the spasms were very frequent, fifty to eighty in the day. Ten months prior to the final attacks there was freedom from convulsions. The intellectual faculties were unimpaired.

The case is unusual in the limitation of the lesion to the ascending frontal convolution and to its fasciculus of white matter, scarcely involving the gray substance which is commonly affected in cortical epilepsy. The accurate localization and the remarkable absence of tissue changes in the immediate vicinity give the case the nature of an exact physiological experiment. With this limited lesion of the motor area there was permanent paralysis with contracture of one extremity and epileptiform convulsions. Another feature of interest in the case is the light it throws on the situation of the leg centre. The fibrous mass was

situated entirely within the anterior part of the paracentral lobule, limited in extent, confined chiefly to the medullary fibres of the superior frontal fasciculus, and only touched the gray matter in places. A point to be referred to is the absence of the paralysis of the leg for the first six years, for, if the convulsions and monoplegia were caused by the same lesion, how explain the late onset of the latter? From the fibroid state of the tumor it might reasonably be inferred that it was originally larger and had shrunk, but the absence of puckering on the surface and the way in which the margins merged with the contiguous parts make it probable that the growth was always small, so small in fact that at one period of its development it may have caused sufficient irritation to induce the convulsions, and yet at the same time not involve the special fasciculi of white fibres to the extent of producing weakness of the leg, or monoplegia.

The Treatment of Stammering.—A correspondent in the *Lancet* writes that stammering may be cured by simply making an audible note in expiration before each word. Stammerers can sing as easily as other persons. Jackey Broster, of Chester, who made a large fortune by curing stammering, simply made his pupils say *her* before each word beginning with a consonant.

Cocaine.—*Dr. F. A. Hansell* (*Polyclinic*) concludes an article on this subject as follows:

1. Two, or at the most, four drops of a two per cent. solution (gr. ix–℥j) dropped into the conjunctival sac at one sitting, is the requisite quantity aud strength.

2. The interval between the instillation and commencement of the operation should not exceed three minutes.

3. Anæsthesia of superficial parts of the eye can be complete, while that of other mucous membranes and the skin is partial or entirely absent.

4. Rubbing is the simplest method of applying to skin.

5. Dilatation of pupil and partial (very slight) loss of accommodation are induced in ten minutes, and continue less than twenty-four hours.

6. No injurious effects follow.

A vegetable growth forms in the solution, which, however, does not impair its activity,

An Obscure Case of Popliteal Aneurism Simulating Sarcoma.—The diagnosis of popliteal aneurism is not generally a matter of great difficulty, still some of the cases of aneurism simulate other diseases so closely that mistakes are occasionally made. Many able surgeons have opened aneurisms, supposing them to be abscesses, and others again have tied the femoral artery for malignant growths, mistaking them for aneurisms. There are not a few cases recorded where an old consolidated aneurism has been mistaken for a sarcomatous tumor. In the January issue of *The American Journal of Medical Sciences* Dr. Francis J. Shepherd, of Montreal, reports an obscure and instructive case of popliteal aneurism, which was under observation for several weeks, and in which there was a total abscence of aneurismal symptoms, and the rational symptoms pointed to sarcoma, either of the periosteum, or the parts about an old popliteal aneurism, for which the patient had been successfully treated some years before. Amputation was performed, and an examination of the tumor showed it to be solid throughout and composed of fibrin, solidified *én masse*. The orifice of the aneurism was at the distal end of the tumor, and the blood therefore flowed from below up, with, of course, a lessened stream; the circulation, owing to the obliteration of the femoral above the tumor, being carried on by collateral branches. As there was no cavity in the tumor the absence of pulsation and bruit is explained. As there was not a single symptom which pointed to aneurism, an accurate diagnosis seems to have been impossible.

Double Infantile Spastic Hemiplegia.—In the January number of *The American Journal of the Medical Sciences*, Dr. S. J. McNutt reports a case of double infantile spastic hemiplegia, with carefully reported notes of the post-mortem appearances, illustrated with seven cuts exhibiting the lesions found. This is believed to be the third, or, at most, the fourth case of its kind upon record. Yet these cases do not appear to be so very uncommon, since four others presenting similar symptoms are known to be now in New York city. As a

distinct condition, even simple infantile spastic hemiplegia has but lately received attention in text-books. For this reason, and on account of the difficulty of obtaining any comprehensive information on the subject, the collection of facts and theories presented in Dr. McNutt's paper is of great value, and must lead to a further study of this interesting condition, Dr. McNutt has collected and tabulated 34 cases in which autopsies have been made, and each of them presented atrophy of the cerebral cortex, near the fissure of Rolando.

The subject of infantile spastic hemiplegia may live to old age. The inception of the disease, however, always dates back to early childhood, or to intra-uterine life. At whatever age seen, its victims are characterized by more or less complete hemiplegic motor inability, atrophy, and contractures, with or without aphasia, monosyllable utterance, dysphagia, dyspnœa, and idiocy, the latter being especially characteristic of the double affection.

The etiology of infantile spastic hemiplegia has been defined as primitive defect, arrest, encephalitis, and hemmorrhage.

Clinically the cases may be divided into three classes, those in which the inception of the condition precedes birth, those in which it occurs after birth, and those of which parturition is the case. The paper concludes with a careful study of the differential diagnosis and treatment.

Note on a peculiar form of Pulmonary Congestion, not generally known and Terminating in Sudden Death; together with a Plea for Cardiac Aspiration.—In a remarkable and suggestive paper in the January of *The American Journal of the Medical Sciences*, Dr. A. H. P. Leuf, of Brooklyn, draws attention to a particular form of pulmonary congestion, which ends in sudden death, and he enters a plea in defence of aspiration of the right heart in these cases for the prompt abstraction of enough blood to allow the heart to regain its normal functional ability.

New Use for Croton Oil.—*Alexander Harvey*, of Gloucester, N. J., late a Justice of the Peace, is the defendant in an action brought by his wife for alimony on account of alleged desertion. The defence offered to the wife's charge is quite novel, and is without precedent in divorce proceedings. The defendant alleges that he left his wife for justifiable cause; that for a period of fully one year she kept him in a state of constant physical pain by the application of croton oil to his undergarments, and that when this came in contact with his skin and was subjected to friction, it acted as torture, especially when walking. When in a state of repose his misery was not so keen. Mr. Harvey was a club man, and was frequently out, as his wife alleges, in the evenings. After the application of the croton oil he was always home at night, and was a peculiarly submissive husband. But for the fact, as he alleges, that his wife revealed the secret of his tortures to a number of married ladies—whose husbands were also members of clubs—the cause of his physical sufferings would probably have never been ascertained. The testimony of the druggist who sold Mrs. Harvey the croton oil and of the physician who treated Mr. Harvey has been recorded.—*Daily Press.*

Cocaine Applied to the Vagina.—*Dr. E. Fränkle*, of Breslau (*Cent. f. Gynack.*, Dec. 6), uses a 20 p. c. sol. (cocain. mur. 1, aq., dist. 3, spt. vin. rect. 2—not to be filtered. If kept, this becomes thick and turbid, but is cleared up by a few drops of alcohol). Painting the vulvo-vaginal mucous membrane; 1, the sensitiveness to pain is considerably diminished, poundings which ordinarily produce painful sensations are felt on the mucous membrane, superficially, hardly at all, and in the deeper parts must be less than without cocaine; 2, inflamed mucous membrane is made free from pain by cocaine, and the pallor which follows its application shows its effect in producing ischæmia; 3, the reflex excitability of the vaginal orifice is diminished. Hence it is of great value in vaginismus. It is useful in anal fissure, and as a preliminary to introduction of the rectal speculum; also as a preliminary to cauterization of the vulva, removal of warts, of a urethral caruncle, and other measures which cause local pain.—*Med. Times and Gazette.*

Iodoform in Erysipelas.—There would seem to be no limit to the uses to which iodoform may be put to in restoring the human form divine to its pristine vigor. In the May number of the *Practitioner*, Mr.

Clark Burnam commends it for erysipelas. He used a solution of one part of iodoform in ten parts of collodion, and found that after a single application of this the pain and heat were relieved, and that the tendency to spread ceased. This good result could not be attributed to the internal treatment adopted nor to the collodion, because Sir James Paget expressly states that it does not check the spread of the disease. —*Lond. Med. Times.*

Incontinence of Urine.—In a lecture on diseases of children, published in the Medical Press and Circular, Robert Lee, M.D., draws a distinct line between that form of incontinence of urine which occurs in the night and that which occurs in the daytime. He says Trousseau first pointed this out and showed that belladonna acted promptly when the incontinenee occurred at night, but not so well when the trouble persisted through the day. In these cases there is a partial paralysis of the sphincter, and strychnine gives the best results.—*Louisville Med. News.*

The characteristics of the cholera epidemic of 1884, as summed up by a committee of the Académie de Médecine, composed of M.M. Dujardin Beaumetz, Hardy, and Proust, are as follows: I. Relative benignity, corresponding with the regular decrease in the gravity of cholera epidemics since 1832. 2. Absence of special premonitory censtitution, as shown by choleriform diarrhœas. 3. Uncertainty, or at least great variability, in the mode of propagation. 4. Many facts showing that the disease is very contagious; many others showing the contrary.—*Med. and Surg. Reporter.*

Specialties and their Relation to the Medical Profession.—Dr. L. Duncan Bulkley, of New York, read a paper on this subject before the American Academy of Medicine in August, 1884, which thus concludes:

1. The science and practice of medicine has, in company with other sciences, become so vast that no one mind is capable of fully grasping every portion of it.

2. Unconsciously, its various departments have become divided up, and from natural causes certain men have become prominent in various departments.

3. The so-called specialties in medicines are each so great and extensive that particular or exclusive attention is now devoted to them, the study and practice in each branch being sufficient to fully occupy one's time.

4. The development of these branches has greatly increased the scope and extent of medical knowledge.

5. Every medical practitioner should be more or less of a specialist, excelling in some particular direction.

6. To properly follow and develop one of these specialties, the medical man should be particularly well educated, theoretically and practically, in general medicine as well as in his special branch.

7. This tendency to specialism in medicine cannot be arrested; but the difficulty tends to solve itself, by the education of practitioners and students in these specialties, so that the majority of simpler cases shall be treated by them, while the more difficult and obscure cases will naturally fall to the specialist who refuses to treat other diseases and confines himself to the practice of a single branch.—*Med. and Surg. Reporter.*

Management of Miscarriage.—*Dr. W. H. Parish*, teaches that the placenta at the fourth month can remain in the uterus for some weeks without producing serious symptoms, *but that it will produce serious trouble before it comes away.* He considers it criminal to let the placenta remain until bad symptoms develop, as has been taught by some authors. As an expert, he would call such action *malpractice.* He related the case of a woman where the placenta was left after a miscarriage. Four weeks subsequently, she was seized with severe hemorrhage; but even then her attending physician failed to remove the decomposing placenta. Four days later, Dr. P. was called in consultation; the woman was moribund; the placenta was removed, but the patient died.

The lecturer considers no practice so fallacious as the use of *drugs* for the purpose of emptying the uterus, more especially of a placenta. The weakest portion of this organ is that to which the placenta is usually attached, the strongest being that which includes the contracting fibres of the cervix. Hence when we give ergot, we close up the cervix and incarcerate the pla-

centa; and we also render the introduction of the finger, for purposes of examination, next to impossible. He would not leave the placenta in the uterus more than an hour after a miscarriage.—*Med. and Surg. Reporter.*

Report of the English Cholera Commission, (*Drs. E. Klein and Heneage Gibbes*). We have the honor to report that the investigations which we have hitherto carried on in Bombay and Calcutta, have yielded the following results: 1. The statement of Koch that "comma bacilli" are present only in the intestines of persons suffering from or dead of cholera is not in accordance with the facts, since "comma bacilli" occur also in other diseases of the intestines, e. g., epidemic diarrhœa, dysentery, and in intestinal catarrh, associated with phthisis. 2. The "comma bacilli" in acute typical cases of cholera, are by no means present in such numbers and with such frequency as to justify Koch's statement that "the ileum contains almost a pure cultivation of comma bacilli." 3. The "comma bacilli" are not present in the tissue of the intestine or elsewhere. 4. The "comma bacilli" in artificial cultivations, carried out by one of us (E. K.), do not behave in any way differently from other putrefactive organisms. 5. Mucus-flakes of the ileum, taken out soon after death from typical acute cholera, contain numerous mucus-corpuscles, many of them filled with peculiar minute straight bacilli. The same bacilli occur also outside the mucus-corpuscles. They are never missed, even when the "comma bacilli" are. 6. These small bacilli have been cultivated by one of us (E. K.), and they do not behave differently from putrefactive organisms. These small bacilli are not present in the tissues of the intestine, or any other tissue. 7. No bacteria of any kind and no organisms of known form and character occur in the blood or any other tissue. 8. A good many experiments have been carried out by one of us (E. K.), with the following results: (*a*) Mice, rats, cats and monkeys were fed with rice-water stools, with vomit, with mucus-flakes of the ileum, first and after having been kept for twenty-four to forty-eight hours. The animals remained normal. (*b*) Inoculations with recent and old cultivations of "comma bacilli" and the small straight bacilli, as well as with mucus-flakes, were made into the subcutaneous tissue, into the peritoneal cavity, into the jugular vein, and into the cavity of the small and large intestine of rabbits, cats and monkeys; but the animals remained perfectly well and normal. 9. The material which we have had hitherto at our disposal has been very good and abundant, and as far as the microscopic work goes we do not think we shall require any more material. We propose therefore concluding our enquiry by the beginning of December, and hope soon after to return to England.—*Med. Times and Gazette.*

Importance of Early Removal of Caseous Lymphatic Glands.—*Dr. Geo. R. Fowler*, of Brooklyn, concludes an article on this subject (*N. Y. Med. Journ.*, Jan. 10) with the following summary: To summarize them I would briefly call attention to these points: 1. That what may appear—and in the opinion of the older teachers was—an innocent cheesy gland, which had become so from an inspissation of its contents, is really the site of an infiltration of material which rapidly becomes propagated and constitutes the so-called caseous lymphadenitis. 2. That this caseous infiltration may be, and in all probability is, either the bearer of, or the soil proper for, the cultivation of the spore or germ upon which the anatomical product known as tubercle depends for its formation. 3. That there is a period of quiescence varying perhaps in different individuals during which no advance in the disease takes place, but during which the patient is threatened with an outbreak of general tuberculosis. 4. Whenever such caseation is within reach of surgical art, the same rule that is applicable to carcinoma and sarcoma—namely, early, thorough and complete removal—should be practised; and this rule might be of service in those doubtful cases where a persistent lymphadenitis, without caseation occurs and no explanation or reason for its existence can be found, as well as to enlarged and indurated glands found in the neighborhood of the site of caseation.

A bill to regulate the practice of medicine was introduced into the Legislature of New York on January 27th. A similar bill to regulate the practice of medicine in the State of New Jersey will be presented to the Legislature of that State.

Vigor of American Women.—*J. L. Furber, M. D.*, in *The Chicago Medical Times*, says: "I am intimately acquainted with an American lady, of Puritan ancestry, who was born in Vermont, brought up to her young womanhood in New Hampshire, came, at the age of eighteen, to Illinois as a 'Yankee school marm,' taught district school for two years, keeping house the while for her two brothers, one of whom was a school-master and the other a lawyer, until on Nov. 30, 1859, she married a physician, and has since that time borne the privations and made the sacrifices required of a physician's wife in the 'New West,' that her husband might help others. In April, 1861, with her three-months-old boy baby in her arms, moved with her husband and his brothers, by ox and horse teams, across the country to Kansas, where she has since resided. This lady, in her girlhood, was so vigorous that she menstruated twice each month, which habit after her marriage became a monthly one, that has continued throughout all her pregnancies. This bodily habit has made it exceedingly difficult for her womb to retain its fruit till full term, in consequence of which she has lost by miscarriages ten boys, chiefly at the sixth month of gestation. Notwithstanding these numerous miscarriages, she has presented her husband with fifteen living children, consisting of eleven boys and four girls, three pairs of twins being included in the number, and having just passed her silver wedding, and being in the forty-sixth year of her age, is to-day in the enjoyment of her customary good health, and hopes to continue her *labors* for some time to come, and to receive naught but the friendly criticisms of the physicians' wives who may have surpassed her in her labors of love. This case is respectfully submitted as a fair specimen of vigor of American women."

Treatment of Diphtheria.—The use of large doses of bichloride of mercury appears to have originated with Dr. G. A. Linn, but to have been so warmly endorsed by Prof. Wm. Pepper as to become known as Pepper's treatment. Dr. Thallen says the drug has been used; 1, as a spray or wash; 2, internally. He doubts the value of local treatment except to soothe. In view of the powerful antiseptic qualities of the drug, 1-20000 part effectually sterilizing bacterial fluid, in view of the relative blood and body-weight, the natural disease-resisting power of living tissue, the fact that elimination of the drug is slower than its absorption, giving it a cumulative action, and its value as an "aplastic antiphlogistic," he suggest that there may be enough of it in the circulation after use of large doses to arrest or modify the septic process. He gives $\frac{1}{10}$ grain at a dose *freely* diluted in water. The condition of the false membrane is the best guide as to increasing, continuing, diminishing or stopping the remedy. Several cases are given illustrating the value of this treatment, no toxic effects were observed. A similar beneficial action was noted in the strangling sore-throat of scarlatina. Jacobi objects to pilocarpine believing that it induces cardiac failure and hastens death. Steam inhalations are sometimes of great value, but abundance of fresh air must be allowed. He is convinced of the utility of turpentine vapor ($\frac{\text{ʒ}}{}$ ss poured into water heated on a lamp or stove every hour or oftener.) He finds the bichloride treatment as a rule very satisfactory. A half grain or more may be given daily to infants and kept up several days. Free dilution (gr. j to 1 qt. of water) obviates salivation and gastro-intestinal disturbance; if these occur in unction with oleate of mercury may be substituted. Dr. J. Lewis Smith impresses the importance and tolerance of alcohol in some cases. Cyanide of mercury has been employed with favorable results in the dose of about $\frac{1}{10}$ gr. and as a gargle, by Erichsen of St. Petersburg and Seleden of Stockholm. Dr. G. A. Linn says that the suffocation from spasmodic closure of the glottis can be relieved by chloride of gold which acts like a charm, is tasteless and causes no nausea. It should be given in distilled water, in $\frac{1}{50}$–$\frac{1}{30}$ gr. doses every hour at two years; in diphtheritic croup it should be combined with the bichloride of mercury, $\frac{1}{20}$–$\frac{1}{12}$ gr. every three hours at three years; $\frac{1}{8}$ gr. to an adult.

Cremation.—The Weekly Medical Review says that a crematorium is to be established in St. Louis. The rules to be followed are similar to those in force at the Lancaster, Pennsylvania, crematorium, which are as follows:

"1. Application. All applicants for cremation of bodies must present a certificate

of death, signed by the physician attending during the last illness, whose standing as a reputable practitioner must be attested by a magistrate or notary public. A blank for this purpose will be furnished by us; but in lieu of this the certificate of the health officers of cities, in legal form, will be accepted.

"2. Preparation of body. The body should be dressed in a shroud of cotton or linen fabric, being particular to avoid all metallic substances—hooks, buttons with metallic eyes, etc.

"3. Coffin. The body should be inclosed in a plain wooden coffin, or, what is preferable, in a coffin made of sheet-zinc; being particular to make the coffin no larger than is needed to contain the body.

"4. Shipment of body. To avoid unnecessary expense, when accompanied by friends, a passenger ticket should be purchased for the body, which is then shipped as baggage, not by express.

"5. Religious services. When religious services at the time of cremation are desired, we will arrange for them with some of our city pastors, if timely notice is given.

"6. Cost. The cost of incineration is $25. The additional expense of conveying the body from the depot to the crematorium, services of undertaker, one coach for friends accompaning the body, and a plain receptacle for the ashes, will aggregate $10. This amount ($35) must be received by us in current funds, postal-order or certified check, before the body is cremated. A hearse will be furnished when desired, at $5, and additional carriages at $3 each. Urns to receive the ashes will also be furnished when desired, as soon as arrangements now in progress are completed."—*Louisville Med. News.*

Lee on Ringworm.—*Dr. Robert Lee* (*Med. Press and Circular*, Nov., 1884), recommends as useful in even the most obstinate cases the following: Let precipitated sulphur be mixed in a mortar with sweet oil, ℥ ss to ℥ j, so as to obtain a thick cream, add to this three drachms of Calvert's carbolic acid, No. 5 solution, that is a mixture containing about 20 p. c. of acid. This must be applied twice a day, night and morning, to the affected parts, and should be gently rubbed in with a finger on a piece of soft leather. The head should also be well washed and brushed with soap and hot water two or three times a week; and if the disease be of long duration it is well to begin by ordering the whole head to be shaved.—*Lond. Med. Record.*

Compression in Carbuncle.—*Ashurst* prefers applying strips of adhesive plaster concentrically as in swollen testicle. They are first applied at the margin and gradually brought more and more inwards, leaving a space in the centre to allow the slough to come out. From the time of application the spreading of the carbuncle is arrested and the pain is greatly relieved. The carbuncle rapidly diminishes in size, and over its centre a small poultice is applied which, after awhile, is changed for resin or zinc ointment.—*Phil. Medical Times.*

Pruritus Ani.—A correspondent of the *Brit. Med. Jour.* recommends to pass a pledget of cotton soaked in the following into the anus, leaving until the next defecation, when it is to be reapplied: Acid. carbolic. gr. xx; tr. opii ℥ iv; acid hydrocyanic. dil. ℥ ij; glycerine ℥ iv; aquam ad ℥vj.

Philadelphia Clinical Society.—Stated meeting, January 23d, 1885. The annual election of officers resulted as follows:—

President.—Dr. Edward E. Montgomery.

First Vice-President.—Dr. John B. Roberts.

Second Vice President.—Dr. Amy S. Barton.

Corresponding Secretary.—Dr. Ida E. Richardson.

Recording Secretary.—Dr. I. G. Heilman.

Reporting Secretary.—Dr. Mary Willits.

Treasurer.—Dr. L. Brewer Hall.

Councillors.—Dr. James B. Walker; Dr. Daniel Longaker; Dr. Clara Marshall; Dr. Henry Beates; Dr. Henry Leffman.

The Treatment of Phimosis without Cutting Operation.—Recently a child, aged 18 months, with a tight phimosis, was placed under ether; I then inserted within the prepuce the end of a pair of dressing forceps, expanded the blades, and with great ease retracted the prepuce behind the glands. The facility and rapidity with

which this was done (the whole process being almost momentarily) and the satisfactory results, lead me to doubt whether it is justifiable to submit any infant to the risk, however slight, attending circumcision (to say nothing of other objections), and in the case of adults (for whom Mr. Richmond's ingenious instrument appears specially intended), it seems to me highly probably at any rate that a similar proceeding could be well borne without anæsthetics, and that it would be preferred by the patient to a tedious gradual dilatation.—HERBERT L. SNOW in *British Med. Journal.*

TUBERCULAR MENINGITIS TREATED WITH FREE PHOSPHORUS.— *W. E. Green*, M.R.C.S., furnishes to the *Practitioner*, the report of a case which began with tubercular laryngitis. She underwent confinement with her second child. About two weeks after she was noticed to do and say stupid things. On the 24th day she had low muttering delirium, from which she was partially roused by loud speaking. This had gone on for two days. No food or drink had been swallowed for some hours; pulse was feeble and slow; pupils unequally dilated and acting very imperfectly to light; temperature 100°4, and cerebral maculæ were well marked. Milk and beef tea were administered, with gr. 1-16 of free phosphorus in oil every four hours. Twenty-sixth day secretions passed unconsciously. Twenty-seventh day delirium not so constant, but great weakness. Thirty-first day, appears better; suddenly awoke to consciousness and asked how long she had been ill. Improved, and had no further meningeal symptoms, but died of gradual exhaustion from acute tuberculosis about three months after her confinement. The baby died two months later of tuberculosis. Dr. Greenury is reputed to have had remarkable success in the treatment of tubercular meningitis with phosphorus.

Medical Items.

Dr. Christopher C. Graham, of Louisville, Ky., died on the evening of February 3d, after a short illness. He was one hundred years old last October. He was born in an old fort near Danville, Ky., and was an associate of Daniel Boone.

A French chemist is said to have obtained from the outer layers of birch-bark a black gum possessing the ordinary properties of gutta-percha, and also the power to resist the injurious influence of the air and the corrosive action of acids.

Mr. H. Tate has determined to spend $50,000 in building a hospital in Liverpool where the poor may be treated homœopathically *and in accordance with the most advanced principles of medical science.*. It is not to be endowed, "each generation being bound to support its own charities."

Benj. Francis Silliman, Prof. of Chemistry in Yale College, the author of "First Principles of Physics and of Chemistry," and editor of the "American Journal of Science and Arts," died in New Haven, January 14, æt. 68, of heart disease.

The "Index Medicus" has suspended publication for want of financial support. An effort will be made to issue it in another shape.

Mrs. Philander Peck, of Chicago, has recently left a legacy of $400,000 for the erection and support of a Home for Incurables in that city.

Dr. R. Lee Payne, of Lexington, N. C., offers a prize of a $50 surgical case for the best essay presented to the Medical Society of North Carolina by any member of that body.

Dr. Marcellus Whitehead, a popular and highly respected physician of North Carolina, died at his home in Salisbury on January 2nd at the age of 64 years.

The British Medical Association created a new section at its recent meeting at Belfast—that of Pharmacology and Therapeutics.

The widow of the late Dr. Geo. Kinnemon, residing at No. 75 E. Pratt St., in this city, offers for sale the late Doctor's phæton upon very reasonable terms.

Ex-governor Abner Coburn, of Maine, who recently died in his 82nd year, bequeathed to the Maine General Hospital $100,000.

Tarnier's is the only real improvement in the forceps since Levret and Smellie—who added length and gave the pelvic curve to it—and like their's it marks an era in the history of the instrument and a mile-stone in its advancing usefulness. There are cases, many cases in which it is not called for; there are some and not a few in which it gives great facility in delivering.—*T. G. Thomas.*

Twenty-two appointments of assistant surgeons to the U. S. Army have been made during the past year. There are now no vacancies in the medical corps of the army.

Dr. A. Van Hoff Gosweiler has been elected assistant physician at the Baltimore Dispensary, at 154 East Baltimore street. Dr. Gosweiler graduated at the Jefferson Medical College of Philadelphia in the Class of 1877.

According to *The Dartmouth*, Dr. O. S. Taylor, of the class of 1809 of that college, living at Auburn, N. Y., completed his 100th year on December 17th. He also graduated from the medical college in 1813, the second class that went out from that institution. As far as is known, he is the oldest living graduate of any American college—*Boston Medical and Surgical Journal.*

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, from Jan. 27, 1885, to Feb. 2, 1885.

Webster, Warren, Major and Surgeon, granted leave of absence for one year on surgeon's certificate of disability.

Taylor, B. D., Captain and Assistant Surgeon, granted leave of absence for one month, to take effect between March 15th and April 1st, 1885. Permission to leave Department limits.

Kean, J. R., First Lieutenant and Assistant Surgeon, ordered for duty in Department Mo.

PROMOTIONS.

Lieutenant-Colonel John E. Summers, Surgeon, to be Surgeon with rank of Colonel, January 9, 1885.

Major Jos. R. Smith, Surgeon, to be Surgeon with rank of Lieutenant-Colonel, January 9th, 1885.

Captain Egon A. Koerper, Assistant Surgeon, to be Surgeon with rank of Major, January 9, 1885.

APPOINTMENT.

Henry J. Raymond, to be Assistant Surgeon with rank of First Lieutenant, January 12, 1885.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE UNITED STATES MARINE HOSPITAL SERVICE from October 1, 1884, to December 31, 1884. (*Concluded*).

Glennan, A. H., Assistant Surgeon. To proceed to Key West, Fla., for temporary duty. Oct. 8, 1884.

Battle, K. P., Assistant Surgeon, granted leave of absence for thirty days on account of physical disability. December 6, 1884.

Brooks, S. D., Assistant Surgeon, to proceed to New York, N. Y., for temporary duty. October 20 and November 26, 1884.

White, J. H., Assistant Surgeon, to proceed to New Orleans, La., for temporary duty. October 3, 1884. To escort insane seaman to Government Hospital for the Insane. December 17, 1884. Granted leave of absence for fifteen days. December 23, 1884.

RESIGNATION.

Smith, Henry, Surgeon. Resignation accepted by the Secretary of the Treasury to take effect Jan. 15, 1885. Dec. 17, 1884.

APPOINTMENT.

White, Joseph H., M. D., of Georgia, having passed the examination required by the Regulations, was appointed an Assistant Surgeon by the Secretary of the Treasury, Oct. 2, 1884.

PROMOTIONS.

Peckham, C. T., Passed Assistant Surgeon, promoted and appointed Passed Assistant Surgeon by the Secretary of the Treasury from Dec. 1, 1884. Nov. 28, 1884.

Ames, R. P. M., Passed Assistant Surgeon, promoted and appointed Passed Assistant Surgeon by the Secretary of the Treasury from Dec. 1, 1884. Nov. 28, 1884.

Devan, S. C., Passed Assistant Surgeon, promoted and appointed Passed Assistant Surgeon by the Secretary of the Treasury from Dec. 1, 1884. Dec. 5, 1884.

Urquhart, T. M., Passed Assistant Surgeon, promoted and appointed Passed Assistant Surgeon by the Secretary of the Treasury from Dec. 1, 1884. Dec. 5, 1884.

Original Articles.

NOTES OF A CASE IN WHICH A PRESYSTOLIC MURMUR WAS EVIDENT DURING LIFE —WITH RESULTS OF NECROPSY, WITH EXHIBITION OF SPECIMEN.*

BY W. J. JONES, M. D.
Resident Physician Bay View Asylum, Baltimore.

Emil T., German, æt. 33 years, laborer, was admitted to the hospital department of Bay View Asylum on December 20, 1884. He says that he enjoyed good health until about four months ago, when, working in a highly malarious locality, he became affected with malarial fever. He had received but little treatment and had had irregular malarial attacks since.

He was employed on a farm on the North Point road and endured much exposure. He became so much worse that he was finally brought up to the city and thence to the hospital. This was during a spell of unusually severe weather, and the exposure, in all probability, precipitated the fatal termination. Upon admission he presented a pale, waxy appearance and was suffering from moderately developed general anasarca. The area of liver dullness was markedly increased inferiorly. A distinct bulging in the hepatic region was noticeable both in the upright and recumbent positions. Splenic dullness was also increased. The urine was highly albuminous, dyspœnea was marked and cough frequent. Over the greater portions of both sides of the chest, there were flatness to percussion, with absence of vocal fremitus and of respiratory murmur, subcrepitant rales in front. Radial pulse was feeble, as was also the cardiac impulse; apex beat in the 5th intercostal space; heart sounds normal at the base. At the apex a well-marked, loud, blubbering presystolic sound was audible. The valve sounds were quite sharp and distinct, showing no sign of regurgitation, no sign of tricuspid disease. There was no purring tremor, nor was there reduplication of the second sound. The foregoing incomplete clinical history was all that was taken at the examination. During the night the patient became rapidly worse and died the next morning before further observations could be made.

The following are the notes of the necropsy made by Dr. Wm. T. Councilman, ten hours after death. The body small, strongly built, pale and anæmic. The lower extremities slightly œdematous; scalp tightly adherent to the calvarium, and pale; skull thin and very round; dura mater and inner meninges pale; the brain anæmic; thyroid small; in the trachea, a slight amount of mucus. The mucous membrane of the last, from the middle to the bifurcation of the bronchi was red and injected. In each pleural cavity about five hundred c.c. of slightly turbid serum. Both lungs adherent to pleura by old fibrous bands. The lungs were hyperæmic and somewhat œdematous. They did not collapse on removal from the thorax. On section there were found numerous areas of consolidation which varied in size from that of a pea to a walnut. These areas were larger and more numerous in the upper lobe of the left lung than elsewhere. The mucous membrane of the bronchi was swollen, red and injected. A small amount of exudation could be squeezed from them. In nearly every instance a small bronchiole could be followed into the middle of one of the areas of consolidated lung tissue. The large veins of the neck and thorax were of ordinary size and full of blood. The left venticle was slightly hypertrophied. There was no dilatation of either auricles or ventricles. The aortic, tricupid, and pulmonary valves were normal. The posterior mitral valve was slightly thickened. The anterior mitral was also thickened and contracted. On the auricular side of the valve there was a thick calcareous mass which projected down to the edge of the valve. On the free edge of this valve were some very small fresh fibrinous vegetations. At the juncture of the valves there was some contraction, and the orifice of the same was slightly narrowed. On testing the valves with water by pouring it into the venticles through the aorta, the uninjured valve floated up against the contracted one and closed the opening. The heart's flesh was firm and in a few places there was a slight amount of fibrinous myocarditis. The right side of the heart was full of coagula. The liver large, weight 4½ lbs. It was hyperæmic and of a dark, slaty color. Spleen large, weight 1¾ lbs., of a dark, almost black color, and of ordinary consistency. The right kidney larger

*Read before Clinical Society of Maryland, January 21, 1885. See page 241.

than the left. The capsules of both were easily stripped off. Slight portions of the kidney substance coming off with them in a few places. The surface beneath the capsules was finely granular. On section the kidneys were hyperæmic. The glomeruli prominent. The cortical portion narrower than normal. A turbid fluid could be pressed out of the pyramids, and on examination this was found to contain fatty epithelial casts, and fatty degenerated epithelium in large quantities. A few hyaline cylinders were also found. Microscopic examination of the kidney showed extensive fatty degeneration of the epithelium of the convoluted tubules. In this epithelium there was found a considerable amount of very fine pigment granules. A few of the glomeruli were shrunken and converted into solid connective tissue masses. In others the capsule was slightly thickened. There was extensive small-celled infiltration in nearly all parts of the kidney. In some places this was so prominent as to almost obscure the other tissues. This case afforded pathological alterations over which one might well linger. The characteristic effects of malarial poisoning were well marked in the liver and spleen. The granular condition of the kidneys presented a recent appearance that strongly suggested a possible malarious origin. The bronchitis and broncho-pneumonia, recent as they certainly were, might very probably be attributed to the effects of the exposure incident to along ride in an unprotected wagon during a bitter winter's day. A point of especial interest, in view of the diagnosis of presystolic murmur, was the pathological condition of the heart. Though the physical conditions of mitral stenosis were found, conditions that produced the presystolic murmur, *intra vitam*, there were no signs of mitral insufficiency. The clinical diagnosis was thus verified. The existence of mitral regurgitation is so constant in cases of presystolic murmur, that its absence in this case is well worthy of remark. More interesting, however, was the condition of the cardiac muscles and cavities. The left ventricle was slightly hypertrophied. This unusual condition in mitral stenosis may, however, find its explanation, as Dr. Councilman suggests, in the granular condition of the kidneys. There was no enlargement of the cavity of the left auricle, nor of the chambers of the right heart, conditions almost always found in the mitral stenosis. This can only be accounted for by the slight degree of stenosis and of not very remote origin. It is thus evident that a small degree of mitral stenosis may produce a murmur of great intensity, and that in its lower grades of development the apical diastolic and presystolic murmurs may exist without insuffiency and without the peculiar purring thrill,or without being succeeded bythe more rarely occurring reduplicated second sound. In view of the vagueness of our knowledge upon the subject of the presystolic murmurs and mitral stenosis, it would hardly be profitable to discuss here the reasons of the possibility of mitral stenosis of slight extent with pronounced blubbering presystolic murmur, or the existence of extensive stenosis without a direct murmur at all, or the existence of presystolic murmur in cases of aortic regurgitation without any lesion of the mital valve at all, as described by Flint.

For the present, then, we are content to present our short and incomplete clinical history together with the specimen illustrating the changes that gave evidence of their presence during life.

Correspondence.

WHISKEY AND WINE IN TOXÆMIC CONDITIONS.

Editors of the Maryland Med. Jour.:

About one year ago I wrote a note to Professor Flint, Senior, calling his attention to whiskey as an antidote in diphtheria, and in his reply, he stated that the fact had already been placed "sub judice" by a physician of Brooklyn, N. Y. Since then my opportunities to observe the disease have been limited, only one case coming under observation. This occurred in a child twelve years of age, a visitor to Dakota from Northfield, Minn. The use of the whiskey in this case resulted, as usual, in aborting the disease in forty-eight hours. It is given not to sustain the patient, but to extinguish the disease like an incipient conflagration. Given in this way, precisely as in rattlesnake-bite, it has not failed under my observation in an experience extending over eighteen years. It may be urged that I am not an expert *diagnostician*, and have not met the genuine dis-

ease. The first part of the proposition I may admit, but the latter can hardly be possible in an experience so extensive, four years of which was in the midst of an epidemic in the State of New Hampshire. Further, whiskey is a means of diagnosis. Given in error, the patient is quickly intoxicated, and no harm if no good is done. Not so if the case be one of diphtheria. A large quantity will be required, varying from one-half to two pints, to produce slight intoxication, and when induced the improvement is wonderful. It is not the object of this article, however, to urge the claims of whiskey in diphtheria, but to suggest the use of wine in a similar manner in diseases of similar type.

It has been my fortune to treat eight cases of rattlesnake-bite, and I can add to the universal testimony in favor of whiskey used forthwith in the terrible toxæmia resulting. Neither is the knowledge of the benefit of wine in snake-bite at all modern. For the bite of the scorpion, Celsus informs us that the scorpion "*contritum cum vino bibunt*"

Who also, I ask, having experience in malarious regions, has not noted the excellence of wine as an antiperiodic? The abstemious man, anæmic, is brought to the verge of the grave by repeated attacks of intermittent fever, notwithstanding his free access to bark, while his neighbor, plethoric from beer-drinking, is totally exempt. In fact wine was the ancient antiperiodic. Referring again to Celsus, in his "*curatio quartanæ febris*," he instructs us, after giving the treatment through several days, "*si postea febris accessit * * vinum copiosus bibere.*" It should be added that the wine was given "*post febrem*," just as bark should be now.

Wine has also been proposed in phthisis pulmonalis in the form of whiskey, and is frequently beneficial, if given freely and early in the disease. And again, I may ask who ever saw the "whiskey-bloat," however much exposed to its causes, attacked by this dread disease? Is it not a prophylactic? On the other hand, the temperate wife who nursed a consumptive husband is reasonably certain to follow him to the grave in a few years.

Recently, contemporaneous with the diphtheria previously mentioned, several very severe cases of erysipelas and one case of post-partum septicæmia occurred in this vicinity. All died except those directed *vinum copiosius bibere*," viz.: two suffering with erysipelas. I was very much impressed with the similarity of symptoms in the above named diseases, and in fact, it is admitted that all probably originated in a toxæmic condition, but I was still more convinced of the utter imbecility of modern medical science to cope with septicæmia. The case of septicæmia was treated by Dr. Rugar, formerly a surgeon at Fort Totten, a man thoroughly educated and competent, and all that modern science could effect was done. Yet death was not delayed, in my humble judgment, by the treatment a single day, perhaps not an hour, and this is the experience of most physicians with the malady. Considering, then, the inefficiency of the usual treatment, and the fact that wine is beneficial in all toxæmic conditions, whether it be malaria or erysipelas, snake-bite or phthisis, the latter of which modern science seems about to place in the category of the former, and in two of them, viz.: snake-bite and diphtheria, it is regarded by some as an antidote, why may it not be used with much hope of benefit in incipent septicæmia, first removing, if possible, the nidus from which the poison emanates. To be effectual, I apprehend it should be literally poured in, that the fire may be quenched before it has had time to kindle in distant parts of the fabric a pleuritis, a cellulitis, or a peritonitis.

Any one of these having supervened, it will then be only beneficial as a supporting remedy.

W. T. Donnell,

Devil's Lake, Ramsey Co., Dakota, February 3, 1885.

Society Reports.

PROCEEDINGS OF THE MEDICAL SOCIETY, DISTRICT OF COLUMBIA.

(*Specially Reported for the Md. Med. Journ.*).

STATED MEETING HELD JANUARY 14TH, 1885.

The Society met with the President, Dr. W. W. Johnston in the Chair, Dr. McArdle, Secretary.

THE DRUG ALVELOZ—ITS USE IN CANCER.

Under the call for pathological specimens.

Dr. J. B. Hamilton said that he had received some time ago, from the State Department, specimens of the drug "Alveloz," which, it was stated, enjoyed a reputation in Brazil of being a cure for cancer. The specimens furnished him were the resin, and a fluid preparation of the resin, called its milk. This latter was the form of drug prepared for use. This fact having been published in the newspapers, he was flooded with applications from persons suffering from cancer, or alleged cancer. He invariably replied that he would furnish their attending physicians with specimens upon their personal application to him, so long as any of the drug remained on hand. The gentleman whom he would present this evening for the inspection of the members of the Society, was a patient of Dr. Townshend, to whom the speaker furnished the drug for use in this case. The gentleman had, for forty years or more, been annoyed by an ulcer near the inner angle of the eye. Ten days ago this was covered by projecting granulations and discharged a foul secretion. Dr. Hamilton did not regard this case as cancer or cancerous in its nature; but he wished to call the attention of members to the rapid destruction of granulations and consequent cicatrization which had taken place. He had another case under observation, and had furnished the drug to other physicians, and he hoped to make a further report at a subsequent meeting of the Society.

DISCUSSION.

Dr. J. Ford Thompson had seen this man once. He had then thought the disease lupoid in its character. He told the patient to return for operation. The speaker had intended scraping with a spoon, and then apply the thermo-cautery. Whilst the drug has proven beneficial in this case, the growth is not cured. It has acted well, however, and deserves further trial.

Dr. Johnston asked if its use caused pain.

Dr. Hamilton replied that, whilst it was considered an escharotic, yet, in the cases in which he had seen it used, it did not cause much pain. He considered a vegetable "escharotic" a remarkable thing. He thought distance and time may have detracted from the value and quality of the drug. In reply to a question by Dr. Garnett, he said there had been no constitutional treatment in this case so far as he knew, whilst the drug was being applied. In employing it himself, he would not desist from the use of the usual constitutional remedies at the same time. The drug itself was only intended for topical use. It was apparent, on an inspection of the case, that the sore formerly and within a few days covered with granulations, which the patient stated had resisted treatment for many years, had now entirely cicatrized; at the upper border there were some angry looking bullæ, which might or might not hereafter become ulcerated. The result so far showed the drug worthy of a further trial.

Dr. A. F. A. King read a paper on

EPIDEMIC CHOLERA,

In which he briefly reviewed the numerous theories suggested in regard to the etiology and propagation of the disease, none of which, he claimed, had been conclusively proven. He recommended that *all* varieties of drinking water should be examined microscopically *before* the appearance of cholera, so that the microscopic contents of unpolluted might be compared with those of polluted waters. He further suggested that if the cholera poison be inoculable and contained in the atmosphere, it might gain entrance to the body through the medium of *wounds* upon the skin and mucous membranes, be they ever so slight, and recommended that all persons attacked with cholera should be critically examined for the detection of such wounds, with a view to the demonstration and disproof of his suggestion. If the traumatic inoculation of the disease were proven, the practical inference was, that during the presence of an epidemic, special care to avoid traumatic injury should be taken, and that having occurred, all wounds, be they ever so slight, should be at once carbolized and dressed with antiseptic cotton (*a la Lister*) to avoid the introduction of cholera germs. From personal experience, and for other theoretical reasons, he had decided to adopt the dilute sulphuric acid treatment, with ice and cold water *ad libitum*, as being most worthy of trial, should we be called upon to treat the disease next summer.

DISCUSSION.

Dr. J. B. Hamilton was very much interested in the paper just read on account

both of the disease under discussion and the manner in which the subject was presented. Whatever advance was made hereafter in the study of the cause of cholera must be made rather through the Bureau of *Ethnology* than that of *Medicine*. Any thorough study of cholera must embrace a strict investigation of the manners and customs of those countries in which it prevails epidemically. There are places in the East where the monthly record will show a death-rate ranging from fifty to one thousand during the various seasons of the year. In the Presidency of Bombay, during the year 1883, there was a mortality of 37,954. In 1875, it was 47,555. Picture the prevalence of any such epidemic in this country. The health authorities would be covered with undeserved ignominy; the newspapers would be filled with comments, and the sanitary officers perhaps hung at the nearest lamp post. There it was not considered extraordinary, and the health officers made their reports with the utmost *sang froid*. In considering the course and progress of the recent epidemics, he said that in the epidemic which prevailed in Egypt in the year 1883, it is doubtless true that the germs of the disease were brought there by the English troops which had been transferred thither from India.

He had read the report of the commission appointed to investigate the matter, and he had carefully studied the beautifully colored plates giving the microscopic appearances of the water examined, but there is nothing in them to indicate any special germ. He found only the ordinary forms of marine algæ.

Without doubt the disease was carried from Egypt to Toulon, as well as Marseilles. Several cases were discovered in Meilles in the summer of the year preceding the outbreak of the epidemic, but the mayor and the sanitary officer thought it best to suppress the publication of the fact, and took every method known to science in order to stamp out the disease and prevent its spread, but in vain. There was a fresh importation from Toulon to Marseilles, in the last summer, and from thence to Naples and Geneva. In Toulon and Marsielles very valuable efforts were made to study the disease. From Marsielles it was transmitted by fleeing refugees. When it appeared in Naples they had a land and sea quarantine, yet some sailors from Marseilles found their way into the port and slept in the *Strada de Parto*, and thence the disease spread.

In Geneva the epidemic was said to be due to impure water. There are two aqueducts supplying the town with water. In the vicinity of one of these 1,500 laborers found shelter. Infected linen was washed in the water of the Scrivia, and thus the disease was carried into the city. When the supply of water from that source was cut off, the disease abated.

Experimenters in these latter epidemics have followed in the paths of the old observers, threshing the old straw most valiantly. They began by analyzing the atmosphere. They noticed that the usual birds were missing. They considered the ozone, and even paid attention to the red sunsets which were even more peculiar in Europe than in America. But later investigations were more scientifically directed. The dejecta were examined and microbes found. This was true of cases of more or less duration. When patients died, as if by lightning stroke—"fulminant," or "*foudrogant*" cases—no microbes were discernable. Everybody now believes in a germ cause for cholera, but the particular germ has not been determined.

In Marseilles, the government furnished as a hospital, a large palace, the Imperial Chateau Pharo, situated in a promontory and surrounded by a park. To this place all patients, who would consent, were removed. Naturally many of the better classes preferred to be treated at home, consequently the poorer people, embracing the most cases, were sent to the hospital. A competent corps of scientists were in attendance, and every effort was made to thoroughly investigate the disease and its causes. The dejecta were examined microscopically and chemically. Microbes were found in abundance when the patients did not quickly succumb. The intestines of dogs, rabbits, and guinea pigs were injected with microbes, but cholera was not produced. Death was caused by the injection of blood from patients in the algid stage. The blood was examined and "rhizoform" cells were found. When poured upon a plate it fell into roleaux, but the red corpuscles were imperfect, broken down, degenerated and flowed in a sticky and tarry manner. But despite all efforts, the Marseilles commission concludes that "we are

better able to say what cholera is not rather than what it is." These investigators found 250,000 bacilli in a litre of fluid. These micro-organisms will readily pass through three layers of filtering paper. As to treatment, the results produced were not better in the hospital than in city, if as good, notwithstanding the ablest physicians of the city were numbered among its staff, 62.4 per cent. died in the hospital, whilst outside the mortality was 57 per cent. But we must remember that the worst cases were taken to the hospital.

Dr. W. H. Taylor said he had made in his mind (as he presumed most physicians here had also made) a general prospective plan of treatment for any cases of cholera that might come under his care should that disease visit this country, but he thought that listening to Dr. King's very interesting paper would modify that plan of treatment in one particular, and that was that he would be disposed to try the dilute sulphuric acid treatment as recommended by Dr. King.

The general plan which he said he had mapped out in the event of a case of cholera occurring in his practice, was in the first place, to treat promptly the choleraic diarhœa, and should the case progress to the stage of collapse, to give nothing but water if the patient would drink it, until reaction commenced, when he would cautiously use opium, alcoholic stimulants and quinine. He believed it had been very clearly demonstrated that stimulants given during the collapse were very likely to cause death when reaction set in. He recollected hearing of the acid treatment when cholera was in this country, in the year 1846, or sometime between that date and 1850; the treatment was vinegar diluted with a solution of common salt in hot water. which was given very freely during the cold stage

In regard to Dr. King's theory concerning the traumatic origin of the disease, which was based upon the acceptation of the germ theory of causation and propagation, it was difficult to arrive at any very definite conclusion, for in the case of severe wounds, surgical or otherwise, the virus or germ would not be apt to effect an entrance into the circulation through such wound, or at all events, not so apt as at the point of some slight unnoticed abrasion of the cuticle, such as the doctor mentions in his paper, but such slight wounds were so common that he, Dr. Taylor, did not suppose there was an individual living with an entirely sound skin, and the class of people among whom cholera finds the largest percentage of victims, are just the class to be most liable to those unregarded abrasions of the surface, for the reason, as stated in answer to Dr. McArdle, that they are unobservant of their persons, and are likely to be itchy, and consequently to scratch themselves more than persons of another order.

Dr. King thought it an error to suppose every human being to be more or less wounded. We constantly find people surrounded by various species of virus and yet escape inoculation. He would again assert that either open wounds form channels of infection or the atmospheric poison is not inoculable.

On motion, the discussion was closed, and the Society adjourned.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING, FRIDAY, JANUARY 2, 1885.

The President, RICHARD A. CLEEMANN, M.D., in the Chair.

DOUBLE UTERUS AND VAGINA.

Dr. Wm. Goodell described a case which had been sent to him on account of pain in the back, various nervous symptoms and difficult coition. The vagina was double throught its entire length. Entrance had apparently been effected indifferently on either side of the septum. The cervices were united like the barrel of a double-barrelled gun. There was a slight divergence of the upper third of the upper fundus. The sound entered three inches into each cavity. The septum was divided up to the cervix, and her physician reports great relief to the general symptoms.

Dr. C. McClelland described a similar case. Pregnancy had progressed to the third month when the case came under his observation. The vaginal septum was complete. The external contour of the cervix was normal but a thin septum extending from the os to the fundus divided the cavity into two parts. The prominence of the uterus was greater on one side of the abdomen. The sound was not passed. The vaginal septum was divided shortly before labor. A living child was delivered. About

the third day after delivery, a mass, apparently of decidua was thrown off after three or four hours of labor-pains. After involution was complete sounds were introduced into the uterine cavities and the handles diverged one and three-fourths inches. A second conception occurred afterward on the other side of the uterus.

Dr. Goodell some years ago had under his care a case which he at first diagnosticated as an extra-uterine pregnancy, as he apparently found the uterus empty, passing the sound into it, while undoubted signs of pregnancy existed. The fetal tumor was larger toward one side of the abdominal cavity, while the uterus was deflected to the other side. He saw the patient every two weeks and made frequent, careful examinations. He sent the patient to the University Hospital and fixed a day for operation. One day while lecturing on the case, he had his hand on the abdomen of the patient and felt and a contraction and hardening under his hand. This so resembled the action of uterine tissue, that he sent the patient to the Preston Retreat for observation. She was delivered spontaneously. There was but one cervix, and one os, but there was a uterine septum higher up dividing the cavity into two parts.

Dr. Harris remarked that the observer, in these cases, is liable to be deceived, because the enlargement of the uterus causes it to rotate, the empty half the uterus admitting the sound in the median line. The uterus too is generally hereby developed, as this form of uterus is probably the result of arrest of development, and its thin walls do not give, to the palpating hand, the normal sense of thickness and resistance.

DOUBLE OVARIOTOMY WITH UNUSUAL COMPLICATIONS.

Dr. W. H. Parish reported the following case: In September, 1884, I saw in consultation with Dr. M. O'Hara, a lady who had been under his treatment for a number months. She was fifty-two years of age and of exemplary habits. The menopause had been established for a number of years and she had enjoyed good health until a few months ago. In June, 1884, she noticed for the first time that here abdomen was enlarged. In July she consulted Dr. O'Hara, narrating symptoms of indigestion. In August the abdomen had become so enlarged as to occasion concern on the part of the patient, and she had submitted to an examination by Dr. O'Hara. About August 15th Dr. D. F. Willard saw her in consultation with Dr. O'Hara, and the diagnosis of the ovarian tumor was coincided in. On September 6th I saw the patient with Dr. O'Hara and also diagnosticated ovarian tumor. The physical signs were the usual ones characteristic of ovarian tumor. There was distinct resonance in each flank, and no indication of fluid in the peritoneal cavity. The abdominal distension had become very considerable, occasioning no little interference with respiration, and was associated with slight œdema of the lower extremities and general emaciation. Removal by operation was urged upon the patient, but was positively refused. After the lapse of ten days I again saw her with Dr. O'Hara. The difficulty in respiration had so greatly increased as to prevent sleep except in the semi-erect position. But little nourishment had been taken and exhaustion had correspondingly increased. In the erect position the pulse was 160 per minute, in recumbency 130. The abdomen measured forty-five inches at the umbilicus. Its shape had changed since my previous visit. In the flanks there was distinct bulging with fluctuation and percussion dullness. I diagnosticated peritoneal dropsy as a complication of ovarian cyst. The œdema of the lower extremities had increased. The patient had requested that she be tapped, and it was with reluctance that I consented to resort to that measure. On September 14th, with the assistance of Drs. O'Hara and J. B. Roberts, I attempted to diminish the size of the abdomen by tapping the cyst, using for that purpose the ordinary trocar and cannula. Only a few drops of thick gummy substance were obtained; the cyst contents were too thick, too jelly-like, to run through the cannula. But a single puncture was made. The patient now gave her consent to performance of ovariotomy.

September 16th.—The patient had been fed and stimulated as her condition demanded or permitted. Pulse 120, resp. 40, temp. 98¾° F. As yet no apparent disturbance from the tapping. September 17th.—Pain referred by the patient to the bowels; three movements, probably resulting from indigestion. September 18th.—Operation performed, previous to the opera-

tion pulse 130, resp. 40, temp. 99° F.; tongue dry and brown; bowels moved twice during the night; still has pain, supposed by the patient to be in the bowels. There were present Drs. O'Hara, A. H. Smith, J. B. Roberts and McElroy. The patient was etherized by Dr. Roberts and the usual incision along the linea alba was made. The tumor was found to be adherent to the anterior abdominal wall. An attempt was made to break up these adhesions, but the cyst wall was so extremely thin that the cyst was soon torn into. Its contents were too gummy to flow, and it was necessary to scoop out this substance with the hand. The contents had the consistance and appearance of calf's foot jelly and was adhesive like gum, sticking to the hand so that it was necessary to strip it from one hand with the other. There were numerous slight adhesions to the intestines, but as the cyst was so extremely thin these adhesions were not troublesome, portions of the cyst wall being left to the intestines. It was soon discovered that the cyst wall had ruptured prior to the operation and that every portion of peritoneal cavity contained quantities of the colloid material and masses of dark grumous blood. The contents had doubtless escaped gradually from a rent in the upper posterior portion of the cyst several days before the tapping. It was the presence of this material in the peritoneal cavity that led me to diagnosticate the coexistence of peritoneal dropsy. There was no serum in the peritoneal cavity. Washing the peritoneal surface with water would not remove the colloid material and it became necessary with hand and sponge to remove it from the under surface of the liver, from about the spleen and kidneys as well as from among the intestines. After emptying the large tumor it was discovered that there was a smaller one about the size of a fetal head, unbroken and without adhesions and partly pressed into the pelvis by the superincumbent larger one. The two tumors presented the same characteristics. They had thin transparent walls with numerous internal alveolæ and thin septæ, with gummy colloid contents. About the base of each, but especially of the larger, there was a limited amount of solid substance The pedicle of each was ligated and dropped into the abdomen. Each tumor evidently grew from an ovary. The general peritoneum, wherever it could be seen or felt, presented innumerable cysts with walls and contents like those of the ovarian cysts. These peritoneal cysts varied in size from that of a millet seed to that of a pea. Many of the larger ones were ruptured by the hand or sponge. These minute cysts were not arranged in clusters with stem-like attachments to the peritoneum, but were isolated and had the appearance of blebs on the peritoneal surface. The peritoneum presented general injection of its capillaries with slight roughening of its surface, but there were no evidences of active or decided peritonitis. The hemorrhage was but trifling and but few ligatures were applied. The abdominal incision extended about an inch above umbilicus. A glass drainage-tube was introduced at the lower angle of the wound and the remainder of the incision was closed with silver sutures.

At the close of the operation, shock was not great, pulse 134. Morphia was given and the patient passed a somewhat comfortable night. No vomiting. *Morning of the 19th*, pulse 138, resp. 34, temp. 100°F. *Evening*, pulse 140, resp. 30, temp. 102°F. Vomiting a little, and abdomen somewhat distended. Face pale and features pinched. Three ounces of pinkish serum from tube. Vomiting checked by swallows of hot water, and a mixture containing creasote and sodii bicarb. Tube washed out with carbolized water. The *third night* was restless, with vomiting. Next morning, pulse 150, resp. 26, temp. 101¾°F.; increased stimulants, and at noon pulse was 138, resp. 26, temp. 100⅜°. *Fourth night*, slept some, less vomiting; she takes koumiss and retains it; *next morning* pulse 140, resp. 20, temp. 100 $\frac{4}{10}$°. *Fifth night*, pulse 120, resp. 22, temp. 101⅛°, stronger. Three ounces of a somewhat offensive fluid were taken from the tube, bowels were moved instantaneously. *Sixth night*, she slept well; pulse 114, resp. 23, temp. 101⅛ °; sutures removed, union complete. Tube slipped out and could not be introduced again. It left a canal with healthy granulating walls. *Seventh night* vomiting returned; she did not receive the usual amount of stimulants during the night. Exhaustion and vomiting increased, without additional rise of temperature, and patient died on the ninth day. The death was doubtless due to exhaustion. The disease of the ovaries and of the peritoneum

was doubtless colloid cancer. The tumor and the material removed from the peritoneal cavity weighed fifty pounds. It seems right to conclude that had the tumors been removed in their earlier stages the patient would have most probably recovered from the operation, and have remained exempt from the disease months or years, or perhaps permanently.

Dr. Montgomery spoke of the advantages of early operation before peritoneal involvement. He also alluded to the dangers of tapping. He gave a short history of a case of ovariotomy without colloid contents and recovery from the operation, but followed by death six weeks later from cellulitis and ascites, the cause being unknown.

Dr. Baer related a somewhat similar case in which the patient recovered, but is now apparently dying from a recurrence of the disease in the upper part of the abdomen.

Dr. Parish, in closing, said that the tapping was done with reluctance, but did no harm in this case. The peritoneal complication made the case hopeless.

OFFICERS FOR 1885.

President—B. F. Baer, M.D.
Vice-Presidents—E. E. Montgomery, M.D., W. H. Parish, M.D.
Secretary—W. H. H. Githens, M.D.
Treasurer—Alfred Whelen, M.D.
Librarian and Curator—T. Hewson Bradford, M.D.
Council—Wm. Goodell, M.D., R. P. Harris, M.D., T. M. Drysdale, M.D., L. D. Harlow, M.D.
Publication Committee—J. H. Packard, M.D., B. F. Baer, M.D., J. C. Da Costa, M.D., J. B. Walker, M.D.
Library Committee—Horace Williams, M.D., D. Murray Cheston, M.D.

The New York Dispensary will in future pay its medical officers a salary of $800 each. In place of thirty-two attending physicians and surgeons who serve one hour or more three times a week, five medical officers will be appointed after a severe competitive examination, to serve four hours daily, except on Sundays and holidays, when but one hour's service will be required.

CLINICAL SOCIETY OF MARYLAND

STATED MEETING HELD JANUARY 16, 1885.

(*Specially Reported for the Md. M. d. Journal*).

In the absence of President, the Vice-President, Dr. R. B. Morison, called the Society to order at 8.30 P. M., Dr. Jos. T. Smith, Secretary.

Dr. Hiram Woods read the first paper of the evening, his subject being,

NOTES ON JEQUIRITY.

(See Journal of Jan. 24, '85, page 231.)

Dr. S. Theobald thought that there was a marked difference in the susceptability of persons to the action of jequirity. He had had two cases, in one of which, three applications of a two per cent. solution produced a severe inflammation on the fourth day; in the second, the two per cent. solution was used as in first case but had no effect, and a five per cent. solution had no effect until applied five times daily. It should be used in a new case for the first time with great care; make one application then wait twenty-four hours to note the effect. As regards the cornea the same rule should be observed as in the old system of inoculating, only select an eye in which the cornea is vascular, if it is clear, danger is to be apprehended from the use of jequirity. He had had excellent results from the use of the drug.

Dr. Woods in reply to a question from Dr. Meierhof, said his after-treatment was usually to let the eye alone.

Dr. Meierhof said in cases which he had seen ice had been applied.

Dr. Woods thought ice might do if the deeper tissues were involved in the inflammation.

Dr. H. Harlan was much pleased with the action of jequirity. He spoke of the case of a woman of forty years of age, who had been treated with lotions of alum, etc. She had in right eye, pannus, cornea ulcerated, with hernia of iris; left eye, good; used two per cent. solution of jequirity with good results. He thought the after treatment pointed to the relief of pain, ice is good, but he usually directs hot water.

Dr. E. M. Schaeffer read a paper entitled,

THE VALUE OF "FORCED DILATATION" OF THE ANAL SPHINCTERS IN THE CURE OF CONSTIPATION.

The occurrence of reflex spasms in parts more or less remote from the seat of irritation is a well-known fact, thanks to the labors of Sayre, Otis and others. In regarding the nervous derangements associated with congenital phimosis; also, the spasmodic strictures, irritable bladders, and neurasthenic disorders, relieved, coincidently, with the section of urethral contractions and narrowed meatuses, *analogy* has suggested the application of this principle of cure in cases of obstinate constipation, fæcal accumulation, etc., in addition to its more common, though probably still infrequent, employment for fissures, hemorrhoids, chronic ulcers, and spasmodic contractions of the anus.

Van Buren, of New York, strongly advocated this simple mechanical procedure, viz.: complete dilatation of the sphincter ani mucles as an efficient substitute for the knife in the above painful affections. Allingham also speaks of it as "a very admirable treatment," and acknowledges that "spasm is often the cause of constipation which is the forerunner of impaction."

The following cases were reported:

Case I. Young lady, æt. twenty-four years; had suffered for *nine* years from headache and nausea, giddiness and fainting spells, great nervousness, irregular heart action, and persistent acne. She *stated* that the bowels acted regularly every day; for some months no special attention was therefore given this function. Finally, she complained of feeling so stopped up that her breathing was impeded. Purgatives effecting no relief, an examination was made and revealed a large fæcal accumulation in the ascending and transverse colon. All attempts to dislodge the mass were futile, until the anus was freely dilated. A rectal tube could then, for the first time, be sufficiently introduced, a deep injection given, and purgatives complete the work. Result, immediate and most satisfactory.

Case II. A policeman, suffering intensely from rectal tenesmus, due to impaction and superficial ulcers. Full dilatation enabled him to effect easy and painless passages for six months subsequently, when he died.

Other cases cited were respectively,—an elderly woman, for some years troubled with spasmodic contraction of the anus, constipation; a sailor having hemorrhoids and obstinate constipation,—and a case of fissure, piles and constipation with anal spasm; to all of which forced dilatation brought entire relief. The instrument used was the ordinary three bladded metal speculum; though Van Buren and Allingham recommend "the thumbs" as meeting all requirements.

Dr. R. Winslow spoke of the cure of fissure of the anus by dilatation, the only instrument needful being the thumbs. He had operated upon a sinus and thought forced dilatation of the anus might have cured the trouble by allowing the parts to rest, but he took the certain method, the knife.

Dr. R. H. Thomas read a paper entitled:

CASE OF HAY FEVER TREATED BY GALVANO-CAUTERY.

He commenced by a few preliminary remarks on the causation of this disease, which he said was not a neurosis but depended upon the action of an external irritant, instancing the so-called grasses upon the sensitive and erectile tissues of the nose. That this was the case was shown by the fact, that when a sufferer from this disease was removed from the exciting cause the symptoms subsided, but returned as soon as he came, even unconsciously, again under its influence. The exciting cause, however, was only one link in the chain of causes which produced this disease. It is necessary in order that the excitant shall act that, besides the individual idiosyncrasy which renders some individuals more liable to the disease, there shall be a diseased condition in the nasal passages. This condition is generally hypertrophy of the tissues over the turbinated bones or over the septum. There is sometimes only a condition of hyperæsthesia of certain parts which is detected by the use of the probe. Besides this, it is not unusual to find polypi or other morbid growths; a defected septum or some projecting spicule of bone. It will be seen by this, that if we can remove the disease in the nasal passages which renders them sensitive to the external irritant, we as entirely break the chain of cause and effect as we do when we send the patient away to regions where he will not be exposed to its action. That this is not merely theoretical has been shown by the successful results of treatment on this method. After describing the operation,

and referring to the published reports of Dr. Roe's cases, Dr. Thomas proceeded to relate a case which he said possessed interest as being unusually severe. The patient, a young man from England, had suffered from catarrh in the nose since early childhood, and had been unable to breathe through his nose for more than a minute or so at a time for years. About six years before he consulted Dr. Thomas, (1883), he had noticed that his catarrh grew worse in the summer. It increased in violence every year, lasting from the first of June to the last of August, and in 1882 culminated in an attack of catarrhal pneumonia which left him so weak that he was unable to return to his business till November. All through the succeeding winter he was unable to go out at night and continually suffered with attacks of bronchitis. In the summer of 1883 the hay asthma returned with increased violence, with all the usual symptoms from which he suffered; inability to lie down, great dyspnœa, which was increased upon slight exertion, such as walking across the room, &c. His physicians fearful of a repetition of the experience of the previous year, ordered a sea voyage. He came to America, and was met at the wharf by Dr. Thomas, who was just starting on his summer vacation, and taken to a place where he would be free from the influence of the exciting cause. Early in September he came to Baltimore for treatment. At this time there was still active hyperæmia of the Schneiderian membrane, and at first only palliative measures were employed. As soon as the intense irritation had subsided the galvano-cautery was used. The condition of the nasal passages, &c., at this time was as follows, viz.: Hypertrophy of the tissues over the middle and inferior turbinated bones and over the septum; adenoid growths in the vault of the pharynx, follicular pharyngitis and laryngitis. The last were evidently secondary to the nasal and naso-pharyngeal affection. Successive applications of the galvano-cautery were made to the hypertrophied tissues of the nose, the applications posteriorly being made through the mouth, under the guidance of the rhinoscopic mirror. Similar applications were made to the enlarged follicles in the pharynx and the adenoid growths were removed with the forceps. For some weeks before his departure the patient said he felt better than ever he did in his life; could breathe through his nostril with perfect ease; was not easily susceptible to cold; if he caught a slight cold he could easily throw it off. After his returned to England he passed through the winter in greatly improved health, though in the spring, in consequence of imprudent exposure, he had had an attack of bronchitis; from which, however, he recovered before the time for the hay asthma to return. About this time he moved to Liverpool. During the dreaded three months he was twice for a few days threatened with a return, but the return did not come. One of these occasions was when he was in a very specially wooded part of England. The three months of intense suffering was therefore exchanged for a very few days of comparative discomfort. This case, which was the severest Dr. Thomas had seen, even threatening life, he considered might be looked upon as a test case, in showing the value of this treatment.

DISCUSSION.

Dr. J. N. Mackenzie referred briefly to his views concerning the pathology and treatment of hay fever as published in the *N. Y. Medical Record* of July 19, and October 18, 1884. (See also, MARYLAND MEDICAL JOURNAL of June 21, 1884). In regard to its treatment with the galvano-cautery, he could report most favorable results; at the same time it should be remembered that the cautery alone is not sufficient to accomplish the maximum of good. We should never lose sight of the important rôle which the vaso-motor system plays in this disease, and should direct treatment accordingly. The amount of tissue to be distroyed will vary with the individual case, but as little should be sacrificed as possible. Dr. Mackenzie first sears the most sensitive portions with the flat knife, a procedure which destroys the terminal nerve filaments, and which is sometimes sufficient to stop the attacks. Should this fail, he destroys the tissue by a deep stellate incision, the special advantage of which consists in the patency of the nostril secured by the resulting cicatrix. It should be borne in mind that the prognosis in a given case will be influenced not only by the special predisposing or exciting cause of the disease, but also by the amount of injury to the respiratory organs or central nervous system to which the latter has lead. Thus, in long standing cases, chronic changes may be produced in the pulmonary

and bronchial mucous membrane or nerve centres which will interfere with a permanent cure. In one case observed by him, emphysema had developed in consequence of the abnormal work thrown on the respiratory forces. Dr. Mackenzie believes that the whole list of so-called reflex nasal neuroses may be explained in this manner, and, that they and the so-called "hay asthma" may be referred to the same category of reflex phenomena. The treatment of the disease by the removal of the local nasal inflammation marks an era in its therapeutics and the time has come for representative acknowledgment of its usefulness on the part of the general body of the profession. Dr. Mackenzie prefers to operate between the attacks, but has twice done so at the acme of the disease with very satisfactory results.

Dr. N. G. Keirle referred to Trousseau as speaking of the dilatation of the anus with the thumbs; also to a case in which a probary used in the throat had set up such violent symptoms of suffocation that it was thought the knife would have to be used.

Dr. R. Thomas did not mean to say that the pollen of grasses is the only cause of so-called hay asthma; at the present time he has under his care a patient who suffers from the same disease in all essential points who is never so well as during the summer. The exciting causes in her case are bad odors of any kind, dust, &c. A colored man recently presented himself at the Clinic who was always similarly effected whenever he went into a room where oysters were being opened. In regard to destroying the hypertrophied tissue, he thought it was very important to bear in mind the advice of Dr. Morrell Mackenzie, of London, that there were wide variations in the size of the turbinated tissues within the limits of health, and that it was bad practice to try to bring those of every one to their ideal shape. No more should be destroyed than is really necessary to relieve the patient. He thought that the operation had proved itself to be the means of cure for hay fever all other remedies, even travelling, being merely temporizing.

A CASE OF CRANIAL FRACTURE.

Dr. J. E. Michael related the following and exhibited pieces of bone removed from the head by trephining. The patient was crushed by a train; when the Doctor saw him he had reacted from the shock sufficiently to render amputation advisable, which was done upon left leg four inches below the knee joint. After operation directions were given to have the wound in the head dressed, when a fracture of the skull was found to have taken plaee. A scalp wound opened into a compound comminuted fracture, the fragments so packed together that they could not be moved. Trephining was done and pieces removed. A slit was found in dura mater; some loss of brain substance; an artery from dura mater spouted and was tied with carbolated silk. Ether was used on account of the great depression. Not a single head symptom has shown itself throughout the days of his treatment. Both wounds remained free from erysipelas, but the left side, opposite wound of the face, was effected, which subsided under treatment. At present a small hernia cerebri exists.

Dr. N. G. Keirle showed specimen of depressed portion of squamous portion of temporal bones; patient had fits and died, and it is a point of interest to know if they were caused by depressed bone.

Dr. R. Winslow thought Dr. Michael's case exemplified the principle that where the blow is direct and strong the brain is less apt to suffer than where the reverse is the case. Fractures of the skull will unite as bones in other parts of the body.

Dr. R. Winslow exhibited specimen of "Pyæmic Knee-joint." The patient was in a bad condition with high fever. He had gotten a nail in his foot which was cured; but in a week his knee-joint became affected, with an enormously distended leg. On July 24th an amputation was done, with a resulting discharge of the patient in four weeks.

Dr. R. Winslow presented specimen of

GUN-SHOT WOUND OF THIRD LUMBAR VERTEBRA AND AORTA.

The patient was a woman in University Hospital, who was shot by her husband; the bullet entering the abdomen one-and-a-half inches to left of linea alba, and three from ensiform cartilage; first seen by Dr. Winslow ten or twelve hours after injury; has some pain, but no elevation of temp.; no vomiting of blood or bloody stool; at point of entrance some tympanites; from point of entrance of bullet it looked as if stomach or large intestine might have been penetrated. As the patient was not in shock, had no fever and no special subjec-

tive symptoms, it was judged best to let her alone, especially as several cases of gun-shot wounds of the stomach had recovered recently in our wards in the service of Dr. Michael. The patient lived five days and two hours, and finally died in collapse, after having suffered severe pain and elevation of temp. It was supposed she died of peritonitis. Autopsy: wound one-and-a-half inches to left of linea alba and midway between ensiform cartilage and umbilicus; some fluid blood in abdominal cavity; no peritonitis whatever; stomach and intestines not perforated; under peritoneum a large extravasation of coagulated blood, which was very thick. After long search a slit was found in the aorta, with everted counter opening and the bullet was found embedded in the body of the third lumbar vertebra; quite turned on its axis, so that its point was directed forward; the spinal cavity was not opened. The patient had no paralysis at any time; urine and bowels normal. This case is one of very marked interest; it is unique that a person with two holes in the abdominal aorta should live over five days. It can only be explained by the occurrence of slow bleeding under the peritoneum which compressed the vessel to a certain extent; also, because the front opening was slit-like. It is prob able that the severe pain felt was due to detachment of the peritoneum from its connections. Whilst laparotomy is certainly indicated in appropriate cases, we must be very careful in selecting the case, or we will only hasten death. In this case it could have done no good. In five penetrating wounds of the abdomen occuring in the speaker's service in 1884, in but one could any benefit have followed abdominal section; in that case he was not seen until fifteen hours had passed and hence the time for action had passed, even if it had been considered proper.

USE OF COCAINE.

Dr. S. Theobald had recently had a case that showed the good effect of cocaine in arresting pain. The case was one of rupture of tympanic membrane; great pain was experienced; a four per cent. solution of cocaine was instilled with complete relief in ten minutes.

Dr. J. C. Thomas had had excellent results from the use of cocaine.

Dr. Meierhof also spoke of its good effects in relieving tension of the eyes in a boy of fifteen years.

Editorial.

THE REPUTATION OF BALTIMORE FOR MEDICAL TEACHING.—It is not an uncommon thing of late years to meet with or hear statements highly discreditable to the schools of this city and the instruction which they impart. We do not pretend to be so unsophisticated as not to know of the existence of great evils in our system of teaching; on the contrary, we are painfully aware of the defects which necessarily arise from the multiplication of medical colleges among us within the past few years, and the great competition for medical students thereby occasioned. Realizing this as we do, we have no desire whatever to shield those who are guilty of prostituting the interests of the profession to personal ends from the fullest responsibility for their shortcomings. But we submit that charges are often very loosely made and insinuations thrown out which are altogether unjust and unfounded.

For instance, in the last number of the *North Carolina Med. Journal* we find a letter written by Dr. R. L. Payne, of Lexington, N. C., and entitled "Open Letter on the Enactment of a Penalty Clause in our Law Regulating the Practice of Medicine, etc.," in the course of which the author writes as follows: "Why, sir, I know a man who professes to be a graduate of one of the Baltimore schools (and I expect he is) who was sent for not long since to attend a sick child. After going through the farce of an examination, he gave the poor little thing an ordinary emetic. This emetic failing to act as speedily as the so-called doctor desired, he made the father of the child catch some house-flies, and after mashing them up with sugar, actually forced the child to swallow them, and then very complacently remarked: 'Well, I guess that'll fetch him.'" * * * "I will mention one more who received a letter which I read, from Prof. Tiffany, of Baltimore, in which the Professor wrote: 'You can come right along to the lectures, as preparatory study under a preceptor is not necessary.' Professors of medical schools should certainly be more careful, more explicit, for this man did go on (and many others do the same) without any preparation, and staid three months in Baltimore and came back a full-fledged doctor—in his own estimation. He says he was offered a position in one of the Baltimore hospitals, and de-

clares that he 'knows as much about medicine as any man.' He is as ignorant as he is conceited, yet, having a large family connection, he is doing considerable practice."

Now there is little in the above extract that can be accepted as proof against the Baltimore schools. One individual "professes to be a graduate of one of the Baltimore schools"—there is no other evidence of the fact; and yet the readers of the *Journal* will not hesitate to accept it with the same confidence as though there were full proof given that it was true. Again, in the second case, the inference is that the person mentioned received his diploma after only three months' study, and it is implied, at least, that this was granted by the University of Maryland, of which Prof. T. is Dean. Now the writer can affirm, with perfect confidence, that no diploma was given by this institution under such circumstances. Attendance upon two winter sessions is requisite to obtain its diploma. As for the statement that "preparatory study under a preceptor is not necessary," it is no secret, being not peculiar to this institution, but common to a large number of the most reputable medical schools in the country. We do not at all approve of this indiscriminate admittance, and hope that the University will not remain long without some standard of fitness for entrance upon the study of medicine. However, it may be said that at the least there is no hypocrisy about the matter, no pretence in the catalogue of educational requirements never enforced, as we have known of in the case of some other schools.

We strongly disapprove of such slip-shod statements and insinuations as those above referred to, and whilst perfectly willing to concede to Dr. Payne sincerity of purpose, and an honest desire to advance the good of the profession, we must insist that no one should make them without giving ample proofs, or at least standing ready to do so. And we would therefore call upon him to supplement his letter by giving the facts, in order that we may know who they are who, as he implies, are injuring the reputation of our city for medical instruction and holding us up as a target for the ridicule and contempt of the country!

Medical Sickness, Annuity and Life-assurance Society of England. — *The Medical Times and Gazette* comments with strong approval upon the successful establishment of the Medical Sickness, Annuity and Life-Assurance Society, which was instituted at the annual meeting of the British Medical Association at Belfast last summer, chiefly through the influence and efforts of Mr. Ernest Hart, a gentleman always foremost in devising measures for the advancement of professional interests. The Society is strictly mutual and all the benefits derived from it accrue to the members. That such an organization was needed in England appears from the fact that in six months the Executive committee was able to invest, in "first-class guaranteed securities of one of the English trunk lines" so large a sum as $12,500 and have an income from premiums of upwards of $30,000. We are glad to herald the success of so laudable an interprise among our brethren in the maternal isle and we hope that their example may find imitators among us. The formation of insurance and beneficial associations within the profession has everything to commend it to our favor and approval. It secures the co-operation of those whose sympathies and interests naturally bind them together, it causes some to provide for future contingencies who otherwise would neglect it, and above all it gives union and strength to our profession, qualities so little known among us and yet so essential to the due exercise of our influence and the security of our rights.

Miscellany.

Dr. E. T. Bruen on Convallaria Majalis.—*Dr. Bruen* thinks we can now estimate with some degree of fairness the proper therapeutic position of this drug. It is safe for clinical use, producing like digitalis, a primary cardiac stimulation exclusively on the heart and its contained ganglia with a probable action upon the vaso-motor system. It differs from digitalis in causinga slight weakening of the pneumogastics. Cumulative effects are not to be apprehended, since its action is usually prompt, a week or ten days deciding its value. It is more acceptable to the stomach than digitalis. Yet it has not been found markedly useful clinical experience. He has found the diuretic action thoroughly unreliable. As a cardiac tonic upon the

testimony of many of the most reliable observers, it is "only occasionally attended with success—very generally with failure." In the following it may be employed with remarkable confidence: In functional heart disorder, especially palpitation and irregular cardiac action due to general debility or tobacco, in anæmia and hysteria. In palpitation and dyspnœa accompanying phthisis, or asthma before cardiac failure from fatty changes ensues. In acute lung disease, as pneumonia with cardiac irregularity when digitalis has failed. Its effect is diminished in heart disease, valvular, or otherwise, in proportion to the fatty degeneration of the heart; digitalis follows the same rule, though not to the same degree. Mitral regurgitant disease is less positively benefitted than other forms of cardiac disturbance perhaps because fatty degeneration is frequently present. Convallaria may be more serviceable in mitral obstructor in which digitalis sometimes fails. If at all useful, it is more of a cardiac regulation than digitalis; it cannot compare, as a cardiac stimulant, with digitalis or caffeine. Dr. B. employs the fl. extract of Parke, Davis & Co., 15 to 20 drops every three hours, until the desired effect.

Bad Results from Cocaine in Eye Surgery.—*Dr. P. D. Keyser* claims to have had some results from the use of cocaine (Merk's in 4 p. c. sol. was employed) in ophthalmic practice. He has had seven cases of personal observation of its use in extraction of cataract, and in three of these panophthalmitis took place, and in one a hemorrhage in the anterior chamber almost immediately after. He had also heard of two other cases of panophthalmitis after its use. He considers this rather a bad showing in its favor in this delicate operation, and it rather intimidates him from its use in these cases, and in iridectomies although as yet his iritectomies have done well. As a local anæsthetic in the removal of foreign bodies from the cornea, strabismus, and such external operations he knows of nothing equal to it.

Does Quinine abort Pneumonia?—*Dr. A. L. Loomis* thought the question really was whether the passive hyperæmia of malarial disease was identical with that of the first stage of pneumonia. Passive hyperæmia, especially in children, gave rise to physical signs that might easily lead to the case being taken for pneumonia; but he did not think such cases of engorgement would go on to the development of pneumonia except under the influence of something else than malaria. It was impossible to stop the course of a lobar pneumonia—a disease which he thought was truly infectious.—*Proc. of Med. Soc. of the State of New York*, N. Y. Med. Journal, Feb. 7.

Action of Quinine on the Blood.—*Dr. Hobart A. Hare* (*Med. Times*) considers as proven: 1. That sulphate of quinia does not cause paralysis of the vaso-motors. 2. That the contraction, when the sulphate is administered during the inflammation, is produced by a direct action on the muscular coat of the blood vessel, and is independent of any vaso-motor action. 3. That it does prevent the migration of the white blood corpuscle in the body particularly when inflammation is present. 4. That this stoppage of migration is due not to any action on the corpuscle itself, but to the contraction of the muscular coat and the decreased heart-power. Because if you have a dilated vessel you must have a thin wall; and if you have a strong heart you have both the *vis a tergo* of the circulation, and also the decreased resistance of the wall in so thin a state, and consequently the corpuscles migrate readily.

Transmissibility of Tubercle by Vaccination.—To settle this question *Dr. Jos. Acker* (*Centralb. f. Allg. Gesundheitspfl. Lond. Med. Rec.*) undertook a series of most carefully conducted experiments. Eighty-seven phthisical persons in the sputa of most of whom tubercle bacilli were present in large numbers, were vaccinated under antiseptic precautions, their skin being carefully washed with soap and alcohol, and the parts kept covered with antiseptic cotton, except during the moments while the lymph was withdrawn by previously sterilized needles. Lymph was taken day by day so long as any was to be had, and two hundred and fourteen preparations were made, the most approved methods as mounting and staining being employed. In no single instance could tubercle bacillus be discovered. Dr. Acker also reported Schmidt's experiments to test the possibility of inoculating tubercle into the subcutaneous tissue of rabbits and guinea pigs,

animals which are extremely susceptible when the anterior chamber of the eye, the pleural and peritoneal cavities are employed. The result was the same as Schmidt's; in not a single instance did he succeed in infecting these animals by subcutaneous injection of tubercle bacilli, although others inoculated at the same time and with the same materials into the eyes or serous cavities succumbed speedily and certainly. Acker therefore concludes that it is only in cases of acute miliary tuberculosis and when blood is allowed to mix with the lymph that the vaccine vesicle can by any possibility contain tubercle bacilli; and that even should such lymph be used, which could not be without inconceivable negligence or perverseness, the skin presents so unfavorable a soil for the bacillus that infection would be in the last degree improbable, though at the same time he would advise the use of lymph taken not later than the seventh day as affording the greatest possible safeguard against infection of any kind whatever.

Chloral in Delirium Tremens.—Chloral is the hypnotic *par excellence*, the most valuable of all the medicinal resources by which we combat this distressing disease. If it may be said that the introduction of bromide of potassium into medical practice "ushered in a new era in the treatment of delirium tremens" (*Balfour*), cutting short the disease and favoring a speedy convalescence; it may also be said that the action of the bromide was relatively slow and dependent on the repeated administration of large doses (℥ ss. or more, every hour), and that the effect on the spinal cord of massive doses was likely to be somewhat depressing; that therefore the subsequent substitution of hydrate of chloral for bromide of potassium has been an improvement on every former method of treatment, enabling the physician to avail himself of a remedy which "in all cases, from the slightest to the most severe, acts rapidly, safely and efficaciously, and which seems to deprive indulgence in drink of all its horrors and nearly all its dangers."—(*Balfour.*)—*Hurd. in Ther. Gaz.*, January.

Death of Dr. D. I. McKew.—Dr. D. I. McKew, a well-known and highly respected physician, died at his residence in this city, on February 10th, at the age of 56 years. Dr. McKew has been ill for some weeks with Bright's disease, and his demise though not unexpected by his friends, is deeply regretted by all who knew him. He was a man of extensive literary and scientific culture, and was endowed with high gifts of character and intellect. A fuller notice of the deceased will appear in a subsequent issue.

Ingrowing Toe-nail.—In *Brit. Med. Jour.*, Nov., 1884, p. 857, Dr. Walton Browne advocates the operation introduced by Mr. Stilwell for in-growing toe-nail and mentioned in *Brit. Med. Jour.* of 1872.—The operation consists in removing all the granulations and hypertrophied skin together with a large portion of the surrounding sound structures from the side of the toe, sometimes making an open wound an inch long and three-quarters inch wide,—then pads of lint saturated with co. ti. benzoin, are applied to the wound. By this means all the diseased parts are removed at once, and a clean healthy wound left to heal by granulation; as contraction takes place, the nail is left perfectly free and there is nothing into which it can be pressed so that recurrence is impossible.—*Lond. Med. Record.*

Treatment of Delirium Tremens.—*Dr. E. P. Hurd*, of Newburyport, Mass. (*Therap. Gaz.*, Jany.) treats this disease by a subcutaneous injection of one-half grain of morphia at the inception of the attack, followed by a tablespoonful of the following mixture which he advises to be repeated every two hours till sleep is induced:

℞. Chloral. Hydrat., ℥ ss.
Tinct. Capsici, f ℥ ss.
Peppermint Water, ℥ vss.
M.

The Johns Hopkins Hospital.—The annual meeting of the trustees of the Johns Hopkins Hospital was held yesterday afternoon. The report of the building committee showing the work done during the past year and the annual financial statements were read. The main point kept in view in the work throughout the year was to complete the heating apparatus in those buildings of the hospital connected with the hot-water service, and to complete the inclosing of those buildings so far as necessary to permit a test to be made of this

heating apparatus. The general results of the year's work were satisfactory, and more was accomplished than was anticipated. The report deals wholly with details of the work done, and has no reference to the progress expected to be made this year. The financial statement shows that the amount available for construction during 1884 was $131,859.82; amount expended, $137,298.76: income account overdrawn, $5,438.94. The question of filling the vacancy in the board of trustees occasioned by the death of Mr. John W. Garrett was not brought up, and the vacancy still exists. Officers were elected as follows: President, Francis T. King; secretary, Lewis N. Hopkins; treasurer, Joseph Merrifield; finance committee, Francis T. King, George W. Corner, Francis White; building committee, Francis T. King, George W. Dobbin, Francis White, George W. Corner, Dr. Alan P. Smith.—*Baltimore Sun*, Feb. 11th.

Observations on the Regeneration of the Vagus and Hypoglossal Nerves.—Since the time of Fontana the subject of the regeneration of cut nerves has been one of great interest and importance, and some experimental work has been done with more or less success. At the present time there seems to be no difference in opinion as to the fact that fibres of the cut ends of nerves will unite with similar fibres; and that the regenerated sensory nerve will still convey sensory impulses and the regenerated motor nerve, motor impulses. In the case, however, of the regeneration of sensory with motor fibres there yet exists considerable uncertainty.

In a very important paper which appears in *The American Journal of the Medical Sciences* for January, Dr. Edward T. Reichert, of the University of Pennsylvania, records some experiments which were made to learn if the fibres of nerves of entirely different origin and function would unite, and if regeneration should occur to know the form of the return of function, or, in other words, to know if a motor nerve was capable of conveying impulses peculiar to another motor nerve. The vagus and hypoglossal were selected as being nerves of distinct origin and function, and in case of regeneration would probably afford the best facilities for accurate observation.

The experiments were performed on dogs, and it was found that the motor fibres of the vagus in all of the five dogs operated upon had actually become united to similar fibres in the trunk of the hypoglossal, and that the hypoglossal fibres conveyed impulses which were peculiar to the vagus apparatus. Moreover, that in at least one dog (the others not being examined in this way) irritation of the sensory fibres in the hypoglossal trunk gave rise to impulses which were conveyed by the sensory fibres of the vagus to the vagus centres, and produced effects like those induced by excitation of the vagus trunk, thus showing in both instances that a motor or sensory nerve can convey impulses peculiar to another motor or sensory nerve of entirely different origin and function; and indicating that at least in some nerves the effects produced by impulses from the periphery are not dependent upon any peculiarity of impulses due to physiological peculiarities of the peripheral sense-organs or nerves through which the impulses are conducted, but upon the peculiar physiological properties of the nerve centres, hence we have respiratory movements, etc., occurring in the tongue brought about by impulses from the vagus centres through the hypoglossal nerve, and effects on the respiration, pulse pressure, and vomiting centre, through impressions carried to the vagus centres by impulses generated in the hypoglossal.

Not only did Dr. Reichert find motor fibres of distinct origin and function united, but we find among the vagus fibres at least three physiologically distinct sets of motor fibres united with fibres of the hypoglossal, viz: fibres conveying *inspiratory* impulses, fibres conveying *expiratory* impulses, and fibres conveying *œsophageal* impulses, the first two sets no doubt consisting of fibres of the vagus going through the recurrent laryngeal to the muscles of the larynx, and the latter set forming part at least of the fibres belonging in the same branch.

Another interesting fact to be noted is that the sensory fibres in the trunk of the hypoglossal at the point of union with the vagus in these experiments, are recurrent fibres (sensory fibres coming from the superior cervical nerves through the descending branch of the hypoglossal and running from the branch towards the centre), and accordingly conduct impressions normally not directly toward the centres as is com-

monly the case with sensory nerves, but first peripherally making a circuit, as it were, before reaching the centres; therefore, since the sensory fibres in the hypoglossal which united with the sensory fibres in the vagus, conducted impressions to the vagus fibres, it is obvious that these impressions were conducted in a direction opposite to that of the normal, thus offering corroborative testimony to the very interesting experiment of Paul Bert in showing that sensory fibres can convey impressions in both directions.

Treatment of Cholera.—In view of the expected visit of the cholera to this country during the coming year, any contribution to medical literature, bearing upon the treatment of this disease, should receive careful and earnest consideration on the part of the medical profession.

By the researches of Dr. Koch, it is now known that acids are most useful to kill the cholera microbe, and have been successfully employed by the profession in Europe.

Dr. Chas. Gatchell, of Chicago, in his "Treatment of Cholera," says: "As it is known that the cholera microbe does not flourish in acid solutions, it would be well to slightly acidulate the drinking water. This may be done by adding to each glass of water half a teaspoonful of Horsford's Acid Phosphate. This will not only render the water of an acid reaction, but also render boiled water more agreeable to the taste. It may be sweetened if desired. The Acid Phosphate, taken as recommended, will also tend to invigorate the system and correct debility, thus giving increased power of resistance to disease. It is the acid of the system, a product of the gastric functions, and hence, will not create that disturbance liable to follow the use of mineral acids."

The following case is reported from Bangkok, Siam, and may be relied on as authentic: About three months ago a native was attacked with cholera. An American Missionary attended him, and administered all medicines he could, but at last the man was so far gone that they gave up all hopes of recovery, and would do no more. Relatives of the patient begging the doctor not to give him up as lost, the doctor thought of Horsford's Phosphate. After the second dose the patient commenced to revive, and in six hours after, he was pronounced out of danger.

Psoriasis—Verruca—Epithelioma, a sequence.—Dr. James C. White, of Boston, in the January number of *The American Journal of the Medical Sciences*, presents brief notes of two remarkable cases of disease—cases extraordinary, not for the rarity of the pathological processes they represent, but for the very unsual sequence of tissue-change exhibited in their course. There were three distinct pathological affections of the cutaneous tissues: psoriasis, verrucous hypertrophy, and epitheliomatous new growth; not occurring independently of each other, but as successive, mutual transformations in the above order.

The three dermatoses which enter into the clinical history of Dr. White's case, and which are in their nature apparently as unlike as their companionship is rare, have a close affiliation in their anatomical relations. The transformation of patches of psoriasis into horny or warty, permanent growths is not referred to in most works on dermatology as of possible occurrence even; the transformation of verrucous growths into epithelioma is of not very frequent occurrence; but the uninterrupted sequence followed in this case, psoriasis—verruca—epithelioma, or in other words psoriasis, as a cause of carcinoma, is extremely rare or unparalled in dermatological history. The practical lesson to be deduced is that the transformation of patches of psoriasis into verrucous hypertrophy must be regarded as an ominous occurrence, and that the softening or other change of such horny growths demands thorough excision without delay.

Dr. H. C. Wood on the Physiological and Therapeutic Effects of Hyoscine.—In a paper (*Therep. Gaz.*, Jany.) detailing a number of experiments and observations upon the physiological and therapeutic action of hyoscine, one of the two alkaloids of hyoscyamus—the crystallizable and therefore presumably the purest one—the following results were attained. The hydrobromate (sometimes hyoriodate) of hyoscine (Merck) was employed.—"Upon the frog hyoscine acts as a motor spinal depressant, killing by arresting respiration probably through a centric influence; when recovery occurs there is no stage of tetanus following the palsy; any influence the alkaloid may exert upon the circulation is of a depressive character, but is so slight as to be of no importance."—

"Upon mammals hyoscine acts chiefly as a spinal depressant; it is a centric respiratory depressant causing death by asphyxia; it has very little effect upon the circulation, what influence it exerts being in the normal animal set aside by the asphyxia it produces; it does not paralyze the pneumogastrics; in enormous doses it paralyzes the vaso-motor system; on the heart itself its influence is very feebly depressant." "The relations between its actions upon the lower animals and upon man are in obedience to the law which I formulated some years since, that as a nerve centre is more and more differentiated it becomes more and more susceptible to the action of drugs. Thus we find the cerebral symptoms produced by the alkaloid in the dog are much more decided than those caused in the mouse, whilst in man the cerebral effect predominates over the spinal. It is plain, however, that in man hyoscine acts as a very feeble sedative on the circulation, a more decided sedative to the spinal and respiratory nerve centres, and a dominant hypnotic upon the brain." "The experiments so far indicate also freedom from disturbance of the secretions and unpleasant after effects. The calmative influence of conium in certain cases of mania is well known, but such action appears to be indirect and due to the motor depressant influence of the drug. From hyoscine we have reason to expect both a direct and an indirect beneficial action." Dr. Wood then details the history of 5 cases of violent mental disease which he has treated with the agent in question with results corresponding to those detailed above. The clinical results which he has so far had with it in cases other than maniacal are very meagre but so far as they go are correspondent with physiological results, which indicate little value for the relief of pain but much for the removal of spasm.

Cocaine in Neuralgia.—During the last three weeks I have used cocaine in six cases of supra-orbital neuralgia with a success which I think justifies a further trial. I commenced by rubbing in a 4 p. c. aqueous solution of hydrochlorate of cocaine, but no beneficial effect was produced, and it was clear that absorption did not take place. I next tried by hypodermic injection over the painful spot of first $\frac{1}{8}$, then $\frac{1}{4}$ and finally $\frac{1}{2}$ grain of the same solution. Relief was almost instantaneous and lasted from 12 to 24 hrs., according to dose. The objection to this treatment is the pain caused by the introduction of even a clean sharp needle. I abandoned this plan and tried the inunction of first a 10 and then a 20 p. c. solution in chloroform. This gave fairly good results but the chloroform evaporates so quickly as to leave much of the salt on the skin. A better solvent is oil of cloves, and I now use a 20 p. c. solution in that, rubbing in 5 to 10 minims with the finger and find that almost instant relief is afforded. I have never met with bad symptoms of any kind. The objection to the treatment is the expense, 100 minims of a 20 p. .c sol. costing about $10. In hospital practice it will be found cheaper to employ percussion, which sometimes gives excellent results or to use a pigment made by rubbing up together eq. parts of chloral, menthol, thymol and camphor. — *Dr. Murrell, in Brit. Med. Jour.*

Erysipelas as a Complication of Pregnancy and Labor.—In *The American Journal of the Medical Sciences* for January, Dr. G. H. Belleray records two cases of labor with concurrent erysipelas without untoward result. He points out that the management of labor in the case of a woman suffering from erysipelas does not materially differ, other things being equal, from the management of a case of normal labor. The accoucheur should abstain from frequent vaginal examinations during labor; and such examinations as are necessary should be made with *clean* hands. The placenta should, if possible, be delivered by Credé's method; thus avoiding the introduction of the finger or hand within the genital canal. A full dose of ergot should be given after the delivery of the placenta; and the uterus should be gently manipulated until it is *firmly* contracted. In the after-treatment, the nurse should be forbidden to touch the genitals of the patient, without having previously washed her hand with *hot* water and soap. The use of antiseptic vaginal injections should be commenced within twelve hours after delivery, and continued as long as there is any indication for their employment,

---

Dr. J. V. Shoemaker has been elected a Fellow of the London Medical Society.

Medical Items.

The directors of the Garfield Memorial Hospital have sent letters to Senators and Representatives inviting them to inspect the hospital, and asking for an appropriation by Congress of $15,000 for expenses of the coming year. In these letters the board say that it has been verbally stated that the reason why the present Congress has so far refused to recognize or aid the hospital in the slightest degree is that it bears the name of Garfield Hospital.

The library of the New York Academy of Medicine contains about 25,000 volumes and 9,000 pamphlets.

Dr. Stanford E. Chaillé has been nominated by the President to fill the vacancy in the National Board of Health created by the death of Dr. Bemiss.

Dr. Abraham Jacobi was elected President of the New York Academy of Medicine, January 15th, vice Dr. Fordyce Barker.

According to the *N. Y. Medical Journal* Birch-Hirschfeld, of Dresden, has been elected as the successor of the late Prof. Cohnheim in the University of Leipsic.

Dr. E. S. Gaillard, the well-known journalist of New York, died on the 2d inst.

Dr. Frank West has resigned the position of Resident Physician to the University Hospital, which he has held for the past five years; the resignation to take effect April 1st. Dr. C. W. Mitchell, a former Assistant Resident, has been appointed to fill the vacancy.

Gaillard's Medical Journal will not be discontinued in consequence of the death of its distinguished Editor, Dr. E. S. Gaillard. The journal will be published by M. E. & E. W. Gaillard, assisted by an able corps of co-laborators.

The Medical Examining Board of Virginia is called to meet at the Exchange Hotel, in the City of Richmond, on Wednesday, April 8th, 1885, at 10 o'clock, A.M., for the purpose of examining candidates for license to practice medicine in the State, and for the transaction of such other business as may be brought before it. The meeting is called by the order of the President, Dr. Wm. C. Dabney, of Charlottesville.

About $36,000 was collected in New York city for the Hospital Saturday and Sunday Fund, a falling off of over $7,000 from 1883. In Baltimore the amount realized was not quite $1,600.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from Feb. 3, 1885, to Feb. 9, 1885.

Town, F. L., Major and Surgeon, granted leave of absence for twenty days.

Waters, Wm. E., Major and Surgeon, granted leave of absence for one month.

Wilson, Wm. J., Captain and Assistant Surgeon, ordered for duty as Post Surgeon, Fort Preble, Me.

Woodruff, Ezra, Captain and Assistant Surgeon, ordered from Willets Point, New York Harbor, to Department of Dakota.

Taylor, Marcus E., Captain and Assistant Surgeon, ordered to the Department of the Missouri.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service for the week ending February 7, 1885.

Long, W. H., relieved at Detroit, Mich. To proceed to Chicago, Ill., and assume charge. Feb. 4, 1885.

Godfrey, John, Passed Assistant Surgeon. To proceed to Vicksburg, Miss., aad Memphis, Tenn., as inspector. Feb. 6, 1885.

Bennett, P. H., Assistant Surgeon. To assume temporary charge of the service at Detroit, Mich. Feb. 4, 1885.

Williams, L. L., Assistant Surgeon. To report to the officer in charge at Detroit, Mich., for temporary duty. Feb. 7, 1885.

RESIGNATION.

Miller, T. W. Resignation accepted by the Secretary of the Treasury, to take effect March 1, 1885. Feb. 4, 1885.

PROMOTION.

Godfrey, John, Passed Assistant Surgeon. Promoted and appointed Surgeon by the Secretary of the Treasury, from March 1, 1885. Feb. 6, 1885.

APPOINTMENT.

Williams, L. L., M.D., of South Carolina, having passed the examination required by the regulations, was appointed an Assistant Surgeon by the Secretary of Treasury. Feb. 6, 1885.

Original Articles.

NOTES ON A CASE OF ELEPHANTIASIS ARABUM.

BY ROBERT B. MORISON, M.D.

Prof. Dermatology and Syphilis in the Baltimore Polyclinic and Post-Graduate Medical School.

Mr. —— æt. 50, married, consulted me sometime ago for a skin affection of the hands and feet, but more especially about a long standing puffiness of the left hand and forearm, which was slightly increased in size; the fingers and back of the hand having a flabby, doughy appearance evidently the result of previous inflammation. The arm above the wrist was more tensely swollen than the back of the hand, half way up to the elbow. No hard knots or swollen glands were felt in the skin thus affected, but the glandulæ cubitales as well as the glandulæ axillares were decidedly enlarged. Both palms were sprinkled over with large and small, round, flattened, brownish-red colored spots, which were evidently specific in character. There was no difficulty in making a diagnosis of psoriasis palmaris syphilitica.

The patient confessed to a chancre dating ten years back, but there was an indefinite history of any secondary trouble, although he acknowledged having gone through with a regular course of treatment at that time. Since the first sore one child has been born to him, which appears to be generally healthy.

Many years ago the patient was shipwrecked on a rocky coast, was left for many hours in the water clinging to ropes and rocks, whereby both hands and feet were frost-bitten. Since this unlucky accident these members have been very sensitive and have been subject to recurrent attacks of eczema. The eczema, however, when relieved did not affect the spots of psoriasis above mentioned. The left hand and arm, besides the other troubles, has for many years been subject to repeated attacks of erysipelas which by this time the patient can foretell, by the sudden increase of pain, œdema, temperature and his general bad feeling. Such attacks occurring several years ago began with red lines which could be followed by their distinct outline half way up beyond the elbow; but latterly as the œdema had been greater they have not been distinct, while the general redness has been more diffuse and intense.

When the patient came to me he was not suffering from an acute attack but desired to be relieved of so unwieldy a hand and arm. He was a man of the most generous habits and drank, as a rule, nothing but dry champagne, which was indulged in to an immoderate degree. The diagnosis of the case was not difficult. The repeated attacks of erysipelas, the consequent chronic infiltration of the cutaneous and subcutaneous tissues, the œdema which never quite disappeared, and the flabbiness of all the parts attacked pointed it out as a case of elephantiasis arabum of the left arm.

The etiology of the disease was the interesting and difficult part of the case. We had two sufficiently good exciting causes, namely, the frost-bite on the one part, and the history of the specific trouble on the other. There was one definite line of treatment indicated however respecting the specific psoriasis palmaris and to cure this the patient was put upon hypodermic injections of Liebreich's hydrargerum formamidatum. Fifteen minim injections of a 1 per cent. solution were given for twenty consecutives days with a satisfactory result—the psoriasis disappeared entirely. The hands then presented a normal appearance as far as any evidence of a former frost-bite was concerned, and the œdema on the back of the left one had decreased perhaps one-half. The patient was then advised to persevere with the internal use of iodide of potash, to keep the hand up as high as possible and to abstain from undue stimulation.

These directions were somewhat indifferently carried out. A legal quarrel, involving a question of character, and causing much mental distress, culminated in a grand row, which caused so much excitement that a violent chill followed at 9 P. M., accompanied by intense pain in the left arm and hand, with swelling, redness and systemic fever. I was summoned at 1 A. M. the same night, and found the arm swollen to three or four times its usual size—I do not mean its normal size, for that had long ceased to be—with all the accompanying symptoms of an acute erysipelas.

This was the first time I had seen the patient in such an attack, but he and his family had become more or less used to them, the severity of this one being the only reason for alarming them.

After a week the man was about again, attending to his business and carrying his arm in a sling. The swelling slowly diminished under the use of India-rubber and muslin bandages, sulphur baths being recommended at the same time, and which were found more or less beneficial. The hand at present is much smaller than when it was first seen, but there is still unmistakable evidence of disease lying dormant, for the puffiness and slight œdema have never quite disappeared. In other words, the *locus minoris resistentiæ* still remains and awaits an exciting cause for just such another attack.

Erysipelas has always begun the increase of size in this case, as it so often does in elephantiasis arabum. In passing, however, it may be said that erysipelas is not a necessary accompaniment of this disease. There are many cases of elephantiasis arabum in which the chronic inflammation is so passive that the gradual increase of the part goes on, the œdema simply increasing and decreasing from time to time without the appearance of any very intense inflammation. There is necessarily an inflammation causing the disease, but it may not be so severe as to represent erysipelas. In the same ratio that we may have recurrent erysipelas without consequent elephantiasis arabum, do we see elephantiasis arabum without recurrent erysipelas.

In the case related erysipelas has always preceded the attacks, and it is not with the idea of discussing how the disease in question generally appears that it has been presented, but to determine the cause in this particular instance. We must, however, in this connection recognize the fact that elephantiasis arabum follows many diseases. It is one of the most serious results which chronic eczema or ulcus cruris leads to; it follows in the wake of a chronic dermatitis, a chronic lymphangioitis, a chronic phlebitis; in fact we must acknowledge that any stasis following any chronic inflammation may end in a thickening of the outer covering which, as it increases, represents typically the disease we are speaking of.

My own opinion, in the present case, is that the primal cause was syphilis. Kaposi says in his last book: "The upper extremities are rarely attached by elephantiasis arabum (following syphilitic or lupus infiltration) and only then in a most unusual manner." Since, in this case, we have the acknowledgment of an initial sore, with subsequent treatment; since there was a psoriosis palmaris, which yielded in the most satisfactory manner to mercury, and since there was, at the same time, a decrease in the size of the arm, I feel justified in my opinion.

As for the frost-bite which had been considered to be the cause of the trouble all along, I think that may be excluded, since the skin of the hands, after the spots had disappeared, was in every respect normal, the nails were not affected, nor was there any want of sensation in the fingers. What else, then, than syphilis could be the cause?

MALIGNANT DISEASE OF THE KIDNEY—WITH AUTOPSY.*

*Read before the Philadelphia County Medical Society, January 28, 1885.

BY DR. EDWARD T. BRUEN, OF PHILA.

The specimen under consideration was removed from a man æt. 60, an inmate of the Philadelphia Hospital. The first symptom of his malady was noticed about six weeks before death. When admitted to my wards he complained of passing pure blood from the penis, otherwise the urine was physiological. He never suffered the least pain; no dullness could be detected in the lumbar region or in the right flank. There was moderate cachexia, indicating the possibility of malignant disease, but little loss of flesh. The hæmaturia continued uninterruptedly until death, prior to which malignant disease was confidently anticipated. The right kidney was found to be enlarged, weighing twelve ounces—about one-half its bulk was filled with malignant new formation situated on the anterior portion of the organ. Microscopic examination by the microscopist of the hospital determined it to be an alveolar sarcoma. The tumor was rich in blood-channels, and part of the bulk of the tumor was entirely made up of clotted blood in a semi-organized condition.

According to Zenker, Schroeder, and others, tumors of the kidney frequently do not arise from the epithelial tissues of that organ. The connective-tissue origin and character of these growths, and their richness in blood-vessels, would assign many so-called carcinomata of the kidney to the group of sarcomata.

The prominent symptom during life was hæmaturia, yet in similar cases the condition of the urine is frequently absolutely negative. Ebstein (Ziemssen Cly.), states that hæmaturia occurred only twenty-four times in fifty cases. Again, authorities unite that long intervals may elapse between the periods of hemorrhage. We can easily understand this since the cavities of the tumor which contain the blood may not communicate with the collecting tubules even in cases of extensive disease, or secretion of urine may be vicariously assumed by the other kidney.

I have even met with cases of abscess of the kidney with only an intermittent discharge of pus. We may assume, however, that causeless and painless hemorrhage from the genito-urinary tract is a very suspicious symptom, indicating malignant disease.

Paroxysms of pain may attend the passage of clots of blood through the ureter, quite resembling those of renal calculus.

The rule ordinarily given in hæmaturia is, that blood escaping from the neck of the bladder or urethra precedes the stream of urine, and whenever blood has accumulated in the bladder in considerable quantity, blood-clots will be passed, but the urine first voided will be clear. In the case reported in this paper, pure blood was frequently passed almost unmixed with urine, so that the previously stated rules differentiating the cause of hæmaturia are of relative importance.

Paroxysmal hæmaturia can be recognized not only by its intermittent character, but by the abundance of the blood-pigment, combined with the rarity of blood corpuscles. The color of the urine in this affection is said to be due to hæmoglobin.

The hæmaturia of renal calculus can be recognized by exclusion only, unless renal colic with unilateral localized pain, or some characteristic sediment, be present; the total amount of urine may be diminished very decidedly, but not otherwise altered. Statements have been made by Heller, Moore, and others, that discharges of "floccule of cancer tissue" may be found in the urine in this class of cases. The altered epithelium of the renal pelvis and ureters has, doubtless, been mistaken for cancer cells, because although certain combinations of cellular material may excite suspicion in connection with other symptoms, nothing definite can be asserted from an examination of the urine. Recently Dr. Julius Wolf (Deut. Med. Wochenschaft, Sept. 25), has stated that iodide of potassium is much less readily eliminated by the kidney during Bright's disease than in health, and recommends the use of four or five grains daily for diagnostic purposes. Some observations by a student of the University of Pennsylvania, Mr. Gregory Guiteras, have confirmed the view—the iodine being absent in the urine in cases of disease of the kidney—but was present in abundance in the saliva. At first sight the test might appear of service in malignant renal disease—but since malignant disease is usually a unilateral process, the test might indicate bilateral disease.

Primary malignant disease of the kidney is not always recognizable by percussion, as was illustrated by the present specimen. The bulk of the growth often projects anteriorly, since the lumbar tissues offer greater resistance. Careful percussion should be made over the lumbar and also the lateral regions; in the latter, percussion should include the space between the lower ribs and the crest of the ileum upward, or forward towards the navel. When tumors of the kidney are very large, and especially when the disease has involved adjacent viscera, the formation may become recognizable anteriorly by palpation, as well as percussion.

These growths are usually adherent to the walls of the abdomen or surrounding parts, and thus become inmovable. They may be round and smooth, or nodular and lobulated, frequently giving rise to a sense of fluctuation, or elasticity, on palpation. They are, therefore, liable to be mistaken for hydatid tumors, and may be confounded with tumors of the liver. In case the growth is situated on the right side, the mistake is particularly possible, but the utmor will not rise or fall with the movements of the diaphragm, and the fingers of the hand can usually be introduced under the ribs on the right side.

These growths, when fluctuating, may indicate puncture with an aspirator as a deciding diagnostic measure, which has been practiced. In one recorded case a whitish-red mass of tissue was obtained, in which the microscope showed a delicate connective-tissue stroma, in which innumerable nuclei were imbedded, and the operation was followed by no bad results.

In renal tumors pain is a pressure symptom, and therefore may be present or absent in accordance with the size and situation of the growth. In malignant disease of the kidney, the cachexia usually noticed in such cases is a late symptom, and in cases of sarcomatous disease is never prominent. Malignant disease of the kidney is more frequent in the early and late periods of life, and is rare as a primary disease, but when present, the other kidney is unusually affected, and it is very seldom accompanied by malignant disease of the lower urinary passages, whereas malignant disease of the testicle, is often followed by renal carcinoma.

Lecture.

INSANITY.

(*Madness—Mental Derangement—Affectus Mentis*).

A Lecture delivered before the Students of the University of Maryland,

By Richard McSherry, M. D.

Professor of Principles and Practice of Medicine, University of Maryland.

The word insanity is made up of *in* and *sanus* (L.), not sane or sound. It is conventionally applied to permanent derangement of the mental faculties. We do not say that a man is insane when under a transient delirium from fever, or from other causes, although the mental faculties for the time being are obviously deranged. The mental imbecility of old age is not called insanity, though it is of course one of its forms—known otherwise as *dementia*.

The varieties of unsound mind, usually recognized by authors, are *mania*, *melancholia*, *moral insanity*, *dementia and idiocy*, with many arbitrary varieties, divisions, and subdivisions.

Mania is the most violent form of insanity, as in fact the term expresses (*fr. Greek, mainomai*, "*I am furious.*") It generally makes its approaches somewhat gradually, so that a person is observed to have some marked peculiarities of manner, speech or habits, which may be considered mere eccentricities, or which may give well-founded uneasiness to his friends. His views may be visionary, his conversation flighty, or unconnected; he may show some unwonted aversions, or seek new associates; in short his conduct may be odd, and unsatisfactory for a greater or less time before it becomes clear that his mind is seriously impaired. There may be, however, no premonitions of a coming change, the patient becoming suddenly and unexpectedly an unequivocal mad-man. These sudden cases are generally due to some sudden or acute malady, as to some form of encephalitis. Headache and fever are the usual concomitants of such attacks. The sudden suppression of habitual discharges, as of the menses in women, or hemorrhoids, or of running ulcers in men, may cause or develop acute mania in the predisposed.

The general health is rarely good in approaching or fixed mania, although the patient may not be conscious of any disturbance. He may have a voracious appetite, or live almost without food; constipation is very common. There are occasional paroxysms of violence or fury, excited by trivial causes, or sometimes without cause. Except in these paroxysms, most patients are but partially insane. They can use their faculties to some extent, though more or less irregularly. In the paroxysms they often lose all trace of reason. In some of the worst cases the old idea of *demonomania* appears to be realized, the patients seeming to be possessed, as indeed, they occasionally declare themselves, by the devil. A man or woman, once of gentle temper, may lay violent hands on the object hitherto most beloved in the world, and while under the furious impulse may take the life of wife, or husband, or parent, or child.

But the paroxysms do not always lead to violence. Sometimes a mad affection is displayed for a familiar, or some new object. Thus I have known a married lady to transfer her affections from her husband to a stranger, and to importune him with expressions of love.

Sometimes between the paroxysms the patient appears quite sane, so much so that the friends often remove him from asylums, under the delusion that he is cured, only to find their mistake when some trivial cause revives the malady, perhaps in increased violence. More commonly there are sufficient evidences of a perverted mind, even when the patient is at his best. He talks more or less incoherently, and shows a total inaptitude for any fixed occupation, or to keep up any connected chain of reasoning. Patients are sometimes insane upon

one or more matters while possessed of their reason in other respects. I have known men to carry on their usual occupations, to converse reasonably upon general subjects, but to manifest "the mind diseased" (mind *disordered* would be a better term), when some particular topic would be brought forward by themselves or others. This form of insanity is called *monomania*. It may take the form of jealousy, or of a particular antipathy, or of some wild speculation, or, in short, it may be a hallucination upon any one subject, or class of subjects whatever, while the faculties in other respects are undisturbed. Some of the spiritualists of the present day appear to be monomaniacs. You may meet with men whose soundness of judgment you must admit in business affairs, who will earnestly assure you that they held a conversation the night before with some person who has been dead for ten, twenty, or a hundred years. In fact, it seems that the human mind may be warped in almost any man by being constantly directed to any one peculiar subject of thought. Thus, a miser, who hoards gold which he does not enjoy, and never means to enjoy, and which gives him sleepless nights with anxiety, is practically, if not confessedly, a monomaniac.

The maniac is generally a sad and mel ancholy being. There are some, indeed, who are quite happy in the possession of imaginary wealth, or honors, but for the most part, they are troubled with anxious fears, with gloomy forebodings, with passive grief and with fancied cares, which to them, are all stern realities. In these matters you may think they are not very different from the sane. It must be admitted that the sane, too, are played upon by their fancies, but generally only so as exaggerate the pleasures or pains of realities. According to Dr. Samuel Johnson, "all power of fancy over reason, is a degree of *insanity*," but the really insane cannot prevent fancy from supplanting reason, while persons of sound mind can, by an effort, subject fancy to reason. *Poco-di-matto*, a slight tinge of madness, according to the Italians, is characteristic of enthusiasts; and Lord Bacon thought it essential to all who aspire to soar into the higher regions of lofty thought or great deeds.* In Macaulay's Essays on "Milton," we read: "Perhaps no man can be a poet, or can even enjoy poetry, without a certain unsoundness of mind, if anything which gives so much pleasure ought to be called unsoundness." The Romans thought that poetry and madness were closely allied, but Horace, whose common sense was conspicuous, repudiates this idea, and blames Democritus for depreciation of sane poets whom he excludes from Helicon, "*Excludit sanos Helicone poetas;*" but Democritus† not only asserted his own opinion; he fortified himself with the same opinion asserted by Plato.

The senses may be perfect in the insane, thus they may see, and hear, and feel, as other persons, although hallucinations of sense are by no means uncommon, but the reasoning faculty is essentially perverted. The memory may be good, but the judgment is at fault. The imagination revels over the judgment. In fact, the imagination is not unlike that of children who have become familiar with fairy stories, or the Arabian Nights. It is apt to be, however, more groveling, or sensuous. Women hitherto modest, may give way to unbridled sentiments of lust, throwing off all the reserve peculiar to the modesty of the sex. Men may become eroto-maniac, or from some sense of mortification or disgust, they have been known to mutilate themselves effectually.

From mania the patient may pass into a state of utter mental imbecility, or dementia, or he may recover entirely; or the disease may cling to him, sometimes subsiding, sometimes aggravated, until he dies of some intercurrent disease.

As to the duration of the disease, the general fact seems to be that the sooner it is brought under treatment the earlier the recovery, if indeed recovery be ever attainable. The longer the patient has been without well directed treatment the less the ultimate prospects of cure.

Melancholia is but a variety of mania, characterized by excessive gloom, mistrust and depression. It varies in degree from a mere depression which renders a person

---

* Great wit to madness sure is near allied,
And thin partitions do their bounds divide."
—*Dryden.*

Which is but a translation in verse of the famous saying of Seneca, "*Nullum magnum ingenium sine mixtura dementiæ.*'

Shakespeare speaks of the poet's brain in fine frenzy rolling, but as Dr. Richardson says, "The so-called poetic 'frenzy' is brain at the point of becoming disorganized in this stage towards dementia." (Dis. of Modern Life, p. 143.)

†Epistola ad Pisones. (Line 295.)

miserable in the midst, it may be, of comfort, while not apparently otherwise of unsound mind, to a gloom that perverts all the mental faculties and that may lead to suicide.

Moral Insanity.—Some psychologists scarcely admit the existence of such an affection as moral insanity. And, indeed, it is difficult to define it, or to find any line of demarcation between this kind of madness and the depravity of the human heart when unrestrained by principles of virtue. But as moral insanity is now admitted by many psychologists, you may accept Dr. Pritchard's definition of it, as being "a morbid perversion of the feelings, affections, and active powers without any illusion or erroneous conviction impressed upon the understanding." I do not know whether moral iinsanity is anything other than giving away to perverse emotions. There are some curious illustrations to be found from time to time of this perversion. A wealthy lady has been known to steal upon all occasions, when she had means to purchase the articles stolen, and when there was no reason to suppose that she was influenced by parsimony. A man may give way to a violent emotion and kill his neighbor without any preceding malice, and this yielding to emotion may be habitual with him, so that the crowning act of murder will not create surprise in those acquainted with his characteristic traits. Such a man would by many persons be held to be morally insane, so indeed in some sense he surely is, but it becomes a very nice medico-legal question as to the legal penalties to be inflicted on a person so affected. There is no doubt a great deal of moral weakness as well as of intellectual weakness among men; and there are degrees of development of the moral as well as of the intellectual faculties. If the last be sound, however, it seems not right to admit that a man may lose his responsibility by mere moral perversion. It really seems doubtful whether a real moral insanity which should be recognized as such can exist without some corresponding disturbance of the intellectual faculties.

Dr. A. S. Taylor, treating upon this subject as pertaining to medical jurisprudence, holds the following just language: "The mental powers are rarely disordered without the moral feeling partaking of the disorder: and conversely it is not to be expected that the moral feelings should become to any extent perverted without the intellect being affected, for perversion of moral feeling is generally observed to be the result of disturbed reason. The intellectual disturbance may be sometimes difficult of detection; but in every case of true insanity it is more or less present, and it would be a dangerous rule to pronounce a man insane when some evidence of its existence was not forthcoming.

The law hesitates at present to recognize moral insanity; hence however perverted the affections may be, a medical jurist must look for some indications of *intellectual* disturbance, *i. e.*, of disturbed reason. Monomania may be accompanied with a propensity to homicide or suicide, and, according to many psychologists, with a disposition to incendiarism or theft."—*Med. Jurip., p.* 627.)

A murderer who escapes conviction under the plea of insanity, ought to be imprisoned for life; if insanity be a false pretext, as it often is, the imprisonment is but a just penalty; if really insane, he ought to be kept among the insane for life, even after apparent recovery; as an insane paroxysm may recur at any time and homicide be again committed.

Dementia.—This form of insanity often results from mania or monomania. It is characterized by a total loss of the faculty of thought, or by such an imbecility of intellect that the ideas are extremely incoherent, there being at the same a total loss of the power of reasoning. It is a lower degree of insanity than mania. The mental faculties are not merely perverted as in mania, but they are destroyed.

Idiocy—Amentia.—Idiocy is sometimes called *dementia naturalis* in reference to its being very commonly a congenital want of mental power. "While mania, monomania, and dementia form the *dementia accidentalis*—idiocy forms the *dementia naturalis* of lawyers." It is not necessarily congenital. It may come on in early life, as the result of organic disease of the brain. There are various degrees of this mental infirmity, some idiots being mere automata, apparently without a ray of intelligence, while others have a limited range of ideas to which they are competent to give expression.

The idiot has a vacant physiognomy, an unsteady step, and an imperfect articula-

tion. There are now schools for the instruction of idiots which are to a certain extent successful; that is, by a well-ordered system, many of them are elevated greatly from a condition resembling that of the lower animals, to a condition of comparative intelligence. A minor degree of idiotism is called *imbecility*, and this imbecility exists in various degrees. Idiots, or imbeciles, do not suffer from hallucinations and illusions like those who labor under mania or monomania.

Besides these distinct forms of insanity there are various mental aberrations to which our race is subject which cannot be exactly classified. In Dr. Wood's work on Practice you will find a section on *Insane Impulse*, e. g., in which a person is impelled to the commission of some criminal or horrible act, as murder or suicide, without reason or cause, while the individual shows no defect of mind in any other respect whatever.

Morbid Anatomy.—It is sometimes asserted that insanity cannot be traced to any lesion of the brain, or its appendages, since in very many cases these are free from all trace of disease. But the assertion is hardly sustained by the facts. There may be a temporary delirium without any appreciable organic change, but in confirmed insanity organic changes are discoverable in nearly all cases upon careful and close inspection. The appearances commonly met with on inspection, are, thickening of the bones of the skull, close adhesions of the dura mater, with great congestion of the pia mater, and opacity and thickening of the arachnoid membrane. There is general fulness of the blood vessels of the brain, with remains of cysts, hardened deposits. or even abscesses, in various parts of the substance of the brain. The brain may be found hardened, or softened, or shrunken, and when shrunken, serous effusion fills the space. The gray substance, now admitted to be the seat of the intellectual powers, is pretty uniformly found to be in some way diseased. The medullary matter may participate in the disease, and usually does if there is the co-existence of palsy. The brain is often wasted, and of less weight than normal—sometimes cavities are found in white substance of convolutions. Hæmatoma auris is often observed. Traces of disease may be found elsewhere; and it is reasonable to suppose that remote disease may have been among the predisposing causes of the attack of insanity. General bad health may result in melancholy, and melancholy in madness. The lungs, liver, stomach and bowels often show traces of disease. In fact, maniacs very commonly die of phthisis. Esquirol observed that in numerous cases of melancholy monomania, the colon dipped perpendicularly behind the pubes instead of crossing the abdomen.

In general *paralysis of the insane* (*manie des grandeurs*) Drs. Poincari and Bonnet have found brown pigmentary degeneration in the ganglionic cells of the whole chain of the great sympathetic nerves to a degree far greaterthan in other cases. In the cervical and thoracic ganglia, they found a substitution of adipose cells for nerve cells, and they are led to believe that this is the starting point of the disease.

The cerebral convolutions and membranes are always in a diseased condition in the *general paralysis of the insane*. In other forms of insanity, lesions are generally found, but not always—and sometimes equivalent lesions are found where insanity has not been observed.

(*To be continued.*)

Lamb Prize Essays.—*Mr. Henry Lamb*, of Rochester, N. Y., has offered through the American Public Health Association, $2800, to be awarded as first and second prizes for papers on the following subjects: 1. Healthy Homes and Foods for the working classes. Prizes $500 and $200. 2. Sanitary Conditions and Necessities of School-houses and School-life. Prizes of $500 and $200. 3. Disinfection and Individual Prophylaxis against Infectious Diseases. Prizes $500 and $200. 4. Preventable Causes of Disease, Injury and Death in American Manufactories and Workshops and the Best Means and Appliances for Preventing and Avoiding them. Prizes $500 and $200. All essays must be in the hands of the Secretary, Dr. Irving A. Watson, Concord, N. H., on or before Oct. 15, 1885. Each must bear a motto and be accompanied by a securely sealed envelope containing author's name and address with the same motto on the outside of the envelope. The judges will announce the awards at the meeting of the Association to be held in Washington Dec. 8–11, 1885.

Hospital Report.

THE PRESBYTERIAN EYE, EAR AND THROAT CHARITY HOSPITAL REPORT FOR MONTH OF JANUARY.

BY HERBERT HARLAN, M. D., ATTENDING SURGEON.

The whole number of cases treated was 668. There were in all 88 operations. Of these 18 were for cataract, 3 for internal squint, 3 for glaucoma, 6 iridectomies and 2 enucleations.

Among other interesting cases may be mentioned more fully, one of lachrymal abscess with fistula, which occurred in a boy of six years. His father stated that the eye had been sore at times for more than a year; that every now and then he would catch cold in it, and that at such times it would be very painful; would then gather, break and discharge, and then for a time be better, but never well. When first seen he had a red and painful swelling over left lachrymal sac. This contained a quantity of pus and had several small, but insufficient openings on the surface. A more free outlet was made and the following day the swelling having somewhat subsided after the escape of the pus, the canaliculus was split up under the influence of cocaine. All this was done without pain to the little patient. The next step, however, the passage of a probe through the duct, both frightened and hurt him, and the result was that I did not see the patient for several days. When next seen a lachrymal fistula was well established. There was no longer any tenderness, but there was a tolerably free discharge through the opening of mucus and tears, and the hard red tumor was still present. I then decided to administer bromide of ethyl and rapidly dilate the nasal duct. This was done and five or six probes of increasing size were rapidly introduced. This was repeated under the same anæsthethic, several days later, the larger probes being used. To my great gratification the tears at once ceased to run over his cheek. The opening closed almost immediately and the swelling and redness have steadily diminished so as to be now, at the end of three weeks, scarcely noticeable.

On two other occasions I have obtained a like happy result from rapid dilatation, under the influence of an anæsthetic.

Correspondence.

"FOR SALE BY ALL DRUGGISTS."

So endeth the reading of all *quack* literature, and the final argument brings a credulous reader's faith in the irresistible panacea to the sticking (or swallowing) point! Patent medicine in Baltimore is having a golden age, judged by its present advances in glaring display and obtruse audacity. The drug stores decorate (?) their windows and floors with packages and false goddesses (in lieu of hygeia), and their walls and pavements hold forth many an oily promise.

Says Dr. Cathell, in his thoughtful look, "The druggists co-operation as retailing agents for quack medicines is indispensable to quackery,"—and adds, that it is responsible for the life of two-thirds of the proprietary trash on the market. I would emphasize the point that the *display* of quackery in drug-stores is the most influential feature of all, for it makes the pretention respectable.

We cannot ask or expect druggists not to keep what is so often called for, but the code has long since recognized our right and duty to discriminate in favor of those pharmacists who do not *push the quack department*. Some *four* or *five* of our leading druggists have taken the stand here advocated, of their own accord, from mere business pride or other motives; and in conversation with such men as John F. Hancock, Croft and Conlyn, etc., the opinion was freely advanced and admitted, that the doctors have this matter in their own hands. The druggist serves the doctor,—but the *tradesman* files the prescription and wraps the medicine-bottle in a seductive circular, throwing in almanacs, guides to health, and other puffery. It was suggested that something could at least be done to disinfect the atmosphere in which *we move*, by quietly meeting the druggists of the city in a conference and expressing our intention, as a body, to aid legitimate pharmacy in this purification. *United* action is absolutely necessary on the part of the medical profession; once have it announced, and understood, that we are alive to our duty in this matter and will recognize those who protect the public from imposture, and sustain their own and our professional dignity, and there will be a marked abatement of the nuisance.

Now is the time to take action. Cut-rates, etc., have made the sale of nostrums less profitable than ever; immense energies are at work to catch the unwary, and the antidote is likely to be effective.

Sanitary reforms require a healthy public sentiment on medical matters. Let us draw the line sharply, here, and help the public to intelligently discriminate, themselves.

E. M. SCHAEFFER, M. D.
323 *Lexington Street.*

Society Reports.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING, HELD, FEB. 5, 1885.

The President, B. F. BAER, M.D., in the Chair.

CERVICAL PREGNANCY.

Dr. E. E. Montgomery read a paper in which he recounted the history of a case seen by him in consultation with Dr. Alexander. The patient had been pregnant eight times; the last labor had been terminated by forceps. The present pregnancy had lasted three months when she was taken with severe pain and quite profuse hemorrhage. An examination under ether disclosed that the cervix was distended forming a globular tumor. The os, turned backward, was filled up with tense membrane; breaking through it, the cervix was found to be a large cavity in which was the fœtus and its envelopes. The body of the uterus appeared like an excrescence upon the distended cervix; it would admit a finger and was lined by a decidua. The membrane below was continuous with the outer mucous membrane of the cervix, so that the remains of it hung as a fringe from the os.

This case differed from the few cases of this condition described, in that there was no contraction of the os; in the majority of cases it occurs in primiparæ and when discovered it was necessary to proceed to artificial measures to make an opening.

Dr. Goodell remarked that he had no knowledge of cervical pregnancy. One case which had been sent to him as such was epithelial cancer of the cervix. How could such a case be diagnosticated without a post-mortem examination? Dr. Montgomery's hypothesis of an arrested abortion is probably the correct solution of such a case as he has described. The fœtus might be forced out of the body of the uterus and arrested in the cervix by an unyielding os or by cicatricial bands. Some years ago a physician of this city, who had a large obstetrical practice, borrowed his écraseur for the removal of a supposed uterine polypus, which proved to be a fœtus in its amniotic sac. Dr. Goodell had never been able to understand how an experienced man could make such a mistake, but the description of this case of cervical pregnancy has thrown light upon the matter. Dr. Montgomery's description of the distended cervix would apply very well to uterine polypus with a long pedicle, and a mistake in diagnosis might easily be made.

Dr. Montgomery questions the primary occurrence of cervical pregnancy. He believes the fœtus has originally taken its seat in the body of the uterus and has been forced into its lower position later; but it might be primary, the internal os being patulous, the same conditions that sometimes cause placenta previa might cause the entire fecundated ovum to be arrested in the cervix.

RUPTURED UTERUS.

Dr. B. F. Baer presented the specimens and related the history (which will be found in full in the *American Journal of Obstetrics*). Mrs. F., colored, 32 years of of age; married ten years; had borne four children at term and had one miscarriage. The first child was forceps-delivered and was still-born. November 14th, 1884, she was taken in labor; a midwife in attendance who pronounced everything correct. After a few hours of severe pains, the patient "felt something break in the womb" and labor ceased, but was replaced with sharp pains all over the abdomen; blood escaped in great quantity from the vagina. Collapse ensued, and she was thought to be dead; a slow reaction occurred, and her attendants waited for labor to begin again. Dr. Fisher was called to see her ten days after the accident. He found her abdomen tender and tympanitic; a mass like the head of a fœtus in the right hypochrondriac region. The pelvis was empty; temp. 103; pulse 108, and small. Rupture of the uterus, and escape of the fœtus into the abdominal cavity was diagnosticated. Dr. Baer was called in and confirmed the diag-

nosis. The patient refused operative assistance and preferred to die in peace; but five days later asked to be relieved. Preparations were made for laparotomy. An examination per vaginam revealed a gangrenous pus escaping freely and the placenta loose and hanging from the vagina; the hand passed readily through the os uteri and through a tare in the right wall of the cervix into the abdomenal cavity and came upon the trunk of the child. The latter was extracted through the vagina byiversion by the feet; it was putrid. The parts were well irrigated with carbolized water, and the hand again introduced entered an adventitious sac and nowhere came in contact with intestines or other viscera. The uterus was well contracted and quite small. The uterus and sac were washed out with carbolized water until it returned pure. The patient died of septicæmia ten days after the removal of the fœtus. Dr. Baer is in full accord with the principles advanced by Dr. R. P. Harris in his paper entitled, "*If a woman has ruptured her uterus during labor, what should be done to her life?*" *Amer. Jour. Obst.*, *Oct.* 1880, *p.* 809, in which he advises that the abdomen should be opened and the peritoneal cavity thoroughly cleansed. In this case, however, nature had protected herself by forming an adventitious cavity, and there could be no reason to open the abdomen to clean this out as it could be reached from below more directly and without injury to the soft parts.

Dr. Henry M. Fisher. In Germany a distinction is made between lymphatic septicæmia and phlebitic septicæmia. In the first form the poison is absorbed by the lymphatics and inflammation of serous surfaces with exudation is the consequence. In the phlebitic form numerous emboli are formed; and hectic fever and local pus formations, the result of these emboli, are found. At the autopsy, in this case, pleural and pericardial effusion was found. It will be remembered that peritonitis occurred very soon after the rupture.

Dr. Goodell remarked that he had come intending to criticise Dr. Baer's treatment of this case for not resorting to laparotomy. But he found himself agreeing with both Dr. Harris and Dr. Baer. In recent cases laparotomy should always be performed, but in fifteen days an adventitious sac had been formed and the dangers to the patient would have been increased by operation, He had seen two cases of rupture of the uterus, both of them occurred in the practice of a physician who never used obstetric forceps, and had to send four miles for a consultant. In the first case peritonitis rapidly supervened; the abdomen became very much enlarged, and the fœtus could not be located by palpation. The abdomen was not opened. After long groping the fœtus was found close under the diaphragm. He had great difficulty in extracting it as the loops of intestines became entangled between its legs; the placenta was also found in the abdomen. In the other case, the body of the fœtus had escaped into the abdomen, but the head was still in the uterine cavity; it was delivered by forceps. Both patients died. In both cases it would have been far better to have opened the abdomen.—*Amer. Jour. Obst.*, *Vol. X*, 1877, *p.* 478.

Dr. Harris is in accord with Drs. Goodell and Baer as to the proper treatment of the case reported. It was too late to do anything when the physician was called. The general opinion is coming around to coincide with his way of thinking concerning the propriety of laparotomy in all cases as soon as reaction from the shock of rupture and hemorrhage has been established. Of the cases reported, after such treatment, fifty per cent. have recovered. One woman has been reported as having ruptured her uterus in four successive labors with delivery per vaginam and without laparotomy, and she survived it all; but such a case is phenomenal. Three cases in Europe have been treated by removal of the uterus as in the Porro operation; they all died; there seemed to be no reason for such a method. In most cases the split extends through the cervix and thus free drainage from the abdominal cavity is secured. One reason for closing the cervical rent by sutures is to avoid the danger of cancerous growths to which that lesion is supposed to give rise.

Dr. Longaker remarked that many of these cases died from the profound shock and hemorrhage immediately following the accident. Two cases in his experience had died within two hours; one undelivered.

Dr. Baer was glad to hear Dr. Harris make the distinction as to the propriety of laparotomy in his case where the patient was not seen until fifteen days after the accident and was suffering from septicæmia.

He had intended to perform laparotomy and was prepared for it, but when he found the newly developed sac, he changed his plan, as he thought nothing could be gained by it.

OVARIAN CYSTS.

Dr. Baer exhibited two ovarian cysts. Mrs. B., widow, entered my private hospital, Dec. 18, 1884. She commenced eight months before to suffer from frequent calls for micturition with severe scalding pains, symptoms apparently of cystitis and urethritis. The uterus and ovaries were in good position and seemed normal; but two weeks later there was a burning pain in both ovarian regions, with perceptible bulging, largest on the right side. The menses had ceased, and the doctor in attendance suspected pregnancy, but exposure was denied at that time. The abdomen enlarged rapidly, and the patient finally acknowledged the possibility of pregnancy, and thought she felt movements of the fœtus. At seven months uterine hemorrhage commenced and continued every day; the mammæ were atrophied, there were no signs of the presence of a fœtus; there was some fluctuation; the sound was passed and the uterus was found empty and not enlarged; the face was wasted and had an anxious expression, and the pulse was quick. A diagnosis of ovarian cyst was now made. A deep diagonal sulcus could made out in the abdominal tumor, the largest portion being on the right side; the tumor was smooth-surfaced and without nodules. The cervix was soft, patulous, high up and drawn to the left. When the tumor was moved the uterus moved with it, as shown by the handle of the sound. Immediate operation was advised and performed. Incision 3¼ inches. Two large tumors were revealed; both were tapped; the left, which was free from adhesions, was withdrawn without difficulty; its pedicle transfixed, ligated and dropped. The larger tumor, although free from abdominal adhesions, could not be drawn out, and it was found to be very tightly adherent to the uterus, which seemed to be one mass with it. As the fluid drawn from this tumor was clear it is not improbable that it was a cyst of the broad ligament. It became necessary to enucleate the cyst, and a long gaping was left in the broad ligament; this was transfixed and tied as a pedicle; but after the final division had been made the ligature slipped and the hemorrhage was increased; ten hemostatic forceps were applied temporarily, and the bleeding points were firmly secured. The wound of the broad ligament was closed by ten interrupted sutures. The operation lasted two-and-a-half hours; the patient collapsed and he feared she would die on the table, but she reacted and recovery was uninterrupted; the patient sat up in two weeks. An accident, which occurred on the fourth day, shows the necessity of the proximity of a physician or thoughtful nurse. A scream from the patient an announcement of a sudden pain on the right side, the patient said something seemed pulling inside of her. Dr. Baer was near and was called; he feared internal hemorrhage, but at once inquired how long it had been since she had passed water—four hours—the catheter was immediately used and complete relief was secured. After this the catheter was not required until the tenth day, but from the tenth to twentieth day there was entire inability to pass water except by assistance of the catheter. She went home on the twenty-third day.

The points of special interest in this case are:

1. The patient being entirely well symptoms of gonorrhœa presented themselves, and were followed by

2. Amenorrhœa for seven months, followed by

3. Daily hemorrhages for one-and-a-half months.

4. Ovaritis and large tumors forming in eight-and-a-half months from the initial symptoms.

Dr. Beates. A young lady was obliged to separate from her husband one month after marriage in consequence of domestic trouble; her menses continued regular, but her abdomen enlarged as rapidly as if she were pregnant; her health failed her, and at the expiration of nine months an ovarian tumor was removed; recovery was complete and rapid.

In another case he found numerous omental and enteric adhesions, which were easily separated; but pelvic adhesions required enucleation of the cyst which left a large V shaped wound in the broad ligament, as described by Dr. Baer; hemorrhage was very free; in trying to dissect off the tumor from the fundus of the uterus, that organ was badly wounded; the cavity

was opened, and required to be closed by sutures. Great tympany followed this operation and breathing became almost impossible; the patient recovered.

CALCULI IN THE FEMALE.

Dr. J. W. Snowden exhibited the stones and related the history of the case. He was called, June 1, 1884, to see Mrs. L., aged 23 years. She was born and has resided in a limestone region in New York. Up to thirteen years of age she was troubled with enuresis; wetting the bed almost nightly. After this she ceased passing her urine during sleep, but was obliged to rise for this purpose two or three times during the night. She could not retain her urine night or day after the desire to pass it came on. If she could not reach a convenient place she would wet her clothes.

She married when seventeen years old. Two months after marriage she began to have cystic irritation, and soon passed sabulous matter and small calculi. These symptoms continuously increased. Physicians whom she consulted said she had catarrh of the bladder, but none made an examination for stone. Once she was obliged to call on a medical man to remove a calculus which had become impacted in the urethra.

Two years ago she spent a summer in New Jersey, during which time she passed no gravel, but the irritation of the bladder continued. When I first saw her she was urinating very frequently, with more or less pain. She passed stones daily with a great deal of sabulous matter. The urine looked as if there was a quantity of ordinary sand in the bottom of the vessel. I proposed an examination for stone, which she refused peremptorily. I gave her benzoic acid, which entirely stopped the passage of the sabulous matter and relieved her in every way; but she still occasionally passed a small calculus. This marked relief lasted two or three months, when irritation of the bladder became worse than ever. She could only pass her urine in the erect position, and with as much effort as a woman in labor. I insisted upon an examination for stone, but the slightest touch excited such intense pain, even when she was well etherized, that being alone I could not manage her, and I sent for Dr. B. F. Baer in consultation.

A calculus, measuring about one-and-a-half inches in its largest diameter, was found in bladder and removed by Dr. Baer after rapid dilation of the urethra. This afforded marked relief, and she soon seemed entirely cured; but in a short time her urine began to dribble continually while she was in the recumbent position at night. During the day she retained and passed her urine naturally. I advised her to get up at stated intervals and empty her bladder, which has gradually relieved this trouble. She is now quite well, except that she urinates rather more frequently than is natural.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD JAN. 22ND, 1885.

The President, DR. SHAKESPEARE, in the Chair.

Dr. G. E. de Schweinitz presented—

TWO CASES OF NÆVUS PIGMENTOSUS.

The first of these specimens is one removed from the face of patient by Dr. John Ashhurst, in the University Hospital. The man was aged about 40 years, and the tumor took its origin in an ordinary mole, which, under the stimulus either of irritants or undue manipulation, grew into a slightly-raised mass with flattened top and constricted base. After Prof. Ashhurst had excised the growth, I made a microscopical examination of it, with the following result: The uppermost portion of the tumor is densely pigmented; and the pigment is further seen to be of a brown or brownish-black color, and contained in spindle or round cells, or to exist as free nuclei and granules. These pigmented spindle cells sometimes are arranged so as to form the boundaries of alveoli, which are in their time filled with moderately large unpigmented lymphoid cells. The base of the mass shows a small-cell infiltrate, enlarged sebaceous glands, and a massing of the epithelium of the part, forming the appearances of squamous epithelioma. Below the fat and subcutaneous tissue presents nothing abnormal. This growth may be classed, I think, as a hypertrophied mole having an epitheliomatous base.

The second specimen was removed by Dr. Agnew, from the back of a man, also a patient in the University Hospital. This tumor developed from a mole, and grew as

a papilla-shaped excresence above the surrounding skin level. Microscopic examination of the mass showed it, like the former one, to be composed of a densely pigmented tissue largely made up of spindle-cells and free granules. Among the interstices of these were numerous blood channels filled with corpuscles. No malignant change at its base was noted and the surrounding skin was normal. Ziegler, in his recent work on Pathology, speaks of the not infrequent occurence of melanotic and alveolar sarcoma, unicellular warts and pigment spots, and certainly some parts of the specimens from the first case are strongly suggestive of a sarcomatous structure.

Dr. de Schweinitz also presented

SPECIMENS OF URETHRAL POLYPI.

These specimens of uretheral polypi were removed from a patient with the following history: ——, aged about 30 years, contracted gonorrhœa, which was unusually stubborn and prolonged in its course. The disease had lasted about 5 months when I first saw the patient. He was then suffering, on account of some imprudence from a moderately sharp attack of cystitis. Having recovered from this and from the acute symptoms of the exacerbation which had probably caused the cystitis, he returned to his former condition of a drop or two of purulent discharge in the morning, which no treatment seemed to relieve. Suspecting then that the long-standing discharge, the diminished calibre of the stream of urine and the feeling of weight in the perineum might be due to a polypus, I explored the urethra with an improved endoscope, and found first two, and later these three polypi; removed them, and had the satisfaction of seeing a cure follow this treatment. They were all situated within the first three inches of the urethra. I think, no doubt these little tumors are papillomas and belong to the more common varieties of new growths which are seen in the male urethra. A rough examination of them with a pocket lens reveals quite nicely their dendritic formation. Tumors of the urethra, in the male, at least, are usually stated to be of rare occurrence, although as William Belfield, of Chicago, has remarked, they may not be so rare as is usually supposed, as the urethra is seldom systematically examined upon the post-mortem table. Belfield himself in a series of 70 autopsies discovered two urethal tumors.

Dr. de Schweinitz then presented

SLIDES FROM AN ADENO-FIBROMA OF LACHRYMAL GLAND.

These sections were made from a tumor of the lachrymal gland, which was removed by Dr. Agnew. The growth occurred in a young man; was of five years duration and painless, having been situated in the upper and outer part of the orbit. The eye was sightless from atrophy of the optic nerve. The tumor, which was about the size of an English walnut, was surrounded by a dense fibrous capsule; the main body of the growth was composed of fibrous tissue through which the remains of the gland tissue are seen. The epithelium is in places in a state of proliferation, but apparently no formation has taken place which could be justly characterized as malignant. The tumor may be classed, I think, as a fibroma or adeno-fibroma of the lachrymal gland.

Dr. C. B. Nancrede presented

SPECIMENS FROM EXCISION OF THE ASTRAGALUS FOR CARIES, ETC.

With the following results: Elmer — æt. 9½ years, had for some years suffered from characteristic symptoms of strumous disease of the astragalus, the details of which it is unnecessary to give. Early in November, 1884, he began to have chills; severe pain in the ankle-joint, which now became swollen; hectic, and profuse diarrhœa. Although I had never been able to detect dead bone by the probe, I felt convinced that an abscess, the result of carious bone, had ruptured into the previously only slightly diseased ankle-joint. I accordingly, under ether, examined the ankle-joint, which I found contained a considerable quantity of very offensive pus, which communicated with a cavity lined with carious bone, situated between the astragalus and os calcis. I excised the astragalus and scraped out the carious external malleolus, as well the roughened surfaces of tibia. The boy has since done well.

Dr. M. Longstreth presented the following specimens, the notes of which, with the discussion, not having been placed in

the recorder's hands as yet, will appear in print at a future time.

1. A kidney, preserved as to color and texture by ordinary illuminating gas.

2. Sarcoma of the femur, removed by amputation by Dr. J. H. Brinton.

Dr. J. Tyson presented the specimens from the following case:—

PYELONEPHRITIS AND CHRONIC PARENCHYMATOUS NEPHRITIS IN THE SAME PATIENT, COMPLICATING CYSTITIS.

E. D——, a prostitute, æt. 25, white, was first admitted to the Philadelphia Hospital Sept. 10th, 1883. She was at that time suffering from diarrhœa, and stated that she had previously passed blood—although apparently none was passed after admission. She had no symptoms which attracted attention to the urinary organs, and no examination of the urine was made. The history of the case at present attainable, does not show whether or not she had had gonorrhœa. Her diarrhœa disappeared under treatment, but she regained strength slowly. She was discharged Oct. 4, 1883, apparently in fair health, but was readmitted on Oct. 25, 1883. She now presented œdema of the legs and face, and an examination of the urine made about this time disclosed the presence of pus. She complained of pain in the lumbar region and in the head, and was much debilitated. The treatment was directed to warding off a threatened uræmia. The dropsy disappeared, but her other symptoms progressively increased until death relieved her. She died with symptoms of uræmia. Autopsy, Dec. 2, 1883. Nothing noteworthy in external appearance. Slight pleuritic adhesions; thoracic organs otherwise normal; peritoneum normal; liver normal; spleen not examined. Kidneys: left, typical, large fatty organ; right, swollen to more than twice its normal size; when opened, found to present a marked pyelonephritis with great distention of the pelvis, the calyces filled with pus—partly fluid and partly inspissated. Bladder was in a condition of chronic cystitis. Cause of death, pyelonephritis, with large white kidney. Dr. Tyson said that the chief interest attaching to the specimens lay in the association of these two very opposite conditions, apparent pyelonephritis or suppurative interstitial nephritis with chronic parenchymatous nephritis. The former condition is a well recognized result of cystitis, the latter not. He had never before met these conditions in association. Usually, as a result of a long continued cystitis however induced, we have a suppurative nephritis of one or both kidneys, but never so far as he knew suppurative parenchymatous nephritis. The most reasonable explanation of the association was that of coincidence. That there had existed, previously, perhaps a chronic parenchymatous nephritis—that upon this a cystitis had supervened, and upon this a pyelonephritis.

In conclusion, Dr. Tyson said that he would like to ask the members whether they had ever found association of these two varieties of diseased kidneys with cystitis?

Dr. Formad thought that he had seen one such case, but there was no history.

Dr. Osler said that the condition of this kidney is not infrequently met with in persons dying of intercurrent affections, and that he should not interpret the case as previous speakers had done. The kidney disease was probably of many years duration, the cystitis was secondary to it, and the other kidney, affected with parenchymatous nephritis, had become subsequently diseased. It was well known that the ordinary scrofulous kidney, with pus in the urine, etc., often lasts for many years, ending in general tuberculosis, or inspissation of the pus. He would like to ask how long pus had been observed in the urine, the state of the bladder, and whether there were other findings or tuberculosis, in the various organs. *

Dr. Tyson replied that he was in the possession of no definite facts as to the duration of pus in the urine. The case had only been under observation for three months, and certainly pus had been detected eight months before her death.

A Case of Unilateral Spasm of the Tongue.—Spasm of the tongue, occurring as an independent affection, is recognized to be quite rare. A case has recently fallen under the care of Dr. Edmund C. Wendt, which he records in the January number of *The American Journal of the Medical Sciences*. The history of the case shows the decidedly beneficial action of galvanism in localized muscular cramps.

* Owing to unavoidable circumstances, a portion of the discussion in which various explanations differing from Dr. Osler's were giveu, has to be omitted.—Recorder.

Editorial.

SHALL AN EFFORT BE MADE TO SUPPRESS QUACKERY IN THIS STATE?—In our issue of January 17th we attempted to show that whilst the States adjacent to this State have either secured, or were attempting to secure, the passage of laws to regulate the practice of medicine within their borders, no effort was being made by the profession in Maryland to protect itself against the hords of quacks and irregulars which were forced to seek refuge in our midst. The question was asked, "Is nothing to be done to suppress the increase of quackery which is pouring into this State?" It was stated that our city is overrun with every species of medical humbuggery, and is the home for the manufacture of every variety of patent medicines and specifics, which vaunt their boastful claims and cure-alls in the most offensive manner before the eyes of our people, and fill our air with their evil and corrupting influences. It was also stated that members of our profession have been contaminated by their morbid surroundings. Prominent citizens, and even city officials holding high positions of honor and trust, have yielded to the seductions of quackery and have given their names to support the claims of nostrums and specifics. That public sentiment is endangered by these influences no one will be able to deny. The medical profession in this city may ignore and ridicule the idea that quacks and quack nostrums are entitled to consideration and notice, but we do not share such opinions. We believe the time has come when the profession should resist the efforts of charlatanism in the work of demoralization and fraud it is perpetrating upon the public. It may be true that the intelligent and thinking classes of people are but little affected by the pretensions of quackery; but it must be remembered that the masses possess but little intelligence when questions of health are presented to their consideration. We know that the public gives an earnest and warm encouragement to quackery in its various forms. The public chooses humbuggery, oftentimes, in preference to intelligent and honest treatment; otherwise how are we to account for the immense expenditure of capital and the enormous pecuniary returns which flow into the pockets of those who follow this branch of trade?

We hold that quackery, in whatever form it is presented, is a dangerous evil. We hold that is the duty of the medical profession as the custodians of the public health to oppose and expose the results of this evil. The medical profession cannot remain altogether silent and withhold its advice in a matter which affects the public health. The method of damning quackery with silence and indifference will not correct or overcome the evil. The medical profession may remain as stiff-backed and as dignified as it chooses in reference to quackery; it may deem it quite unworthy of notice or of consideration; it may rest its claims upon its scientific superiority and august authority and let the people choose which it will accept; but we believe the this method of dealing with the evil is false in policy and wrong in conduct. No revolution against heresy was ever successfully carried on after such methods as we have named.

If wholesome views of medicine are to prevail, if respect and authority for scientific work are to extend to every class of citizens the medical profession must meet this evil and denounce in the most emphatic manner the viciousness and fraud of quackery and quacks.

We do not propose to suggest the methods of resisting quackery at this time. It is quite evident to many medical men that there are means within the power of the profession which, if exercised by organized effort and authority, would go a long way toward breaking down the influence of quacks. A law to regulate the practice of medicine in this State will do a valuable work.

A correspondent in another column sends us a suggestion that we can better face the public after we have purified our own atmosphere by aiding legitimate pharmacists to refuse a place to the *insignia* of quackery. There are a number of ways by which the spirit of our code can be enforced and the authority of our craft elevated and enlarged.

Let us encourage a more wholesome public sentiment upon all questions of public health; let us recognize our duty to the public as promotors of rational methods of combatting disease, and as avowed enemies of every species of humbuggery and trickery devised by man to ensnare public credulity and weakness.

We again ask some of our readers to discuss this question in its true light if we exaggerate its importance.

Proposed State Medical Examination in New York.—The Medical Society of the State of New York (the new-code society) at its recent meeting in Albany, adopted a "Medical Examiners' Bill," the full text of which is given by the *New York Med. Journal*, and decided to urge its adoption by the Legislature of the State. This bill provides for the appointment of a board of medical examiners, consisting of nine persons, six of whom should represent the society, and the other three the other incorporated State Societies (Homœopathic Eclectic, and the old-code Society recently formed). The nine members of the Board will be nominated by the Board of Regents of the University and appointed annually by the Governor. They are to be paid out of the surplus fees, not over $600 per annum, except in the case of the secretary. Applicants must pay a fee of $15, must have studied three years during two winter courses; and must present a diploma from some legally incorporated medical college of this country or Europe; must pay a further sum of $5 for a license, and must register in the county clerk's office. Heavy fines and imprisonment are imposed upon those violating the law. The bill seems to have met with very general approval and acceptance, and our contemporary ventures the opinion that it has a reasonable prospect of being adopted by the Legislature.

Honor to Sir Joseph Lister.—Emperor William of Germany has just conferred on this eminent surgeon the "*Order pour le Merite*" for Science and Arts, thereby acknowledging the infinite service rendered to humanity by the author of the antiseptic method. No nation has been more ready to adopt and to hold fast to ter's teachings, upon which many have man so quick to cast slurs, than the Ger- this h No right minded man will deny that we look or has been well deserved, for when we find tha broad upon the field of surgery complished since th great revolution has been ac- safety and certainty o reform arose, that the has been immensely increased. surgical operations

It is a singular fact that the German mind has seemed to appreciate the merit of great English discoveries more quickly, or at least more generally, than the English. Such was the case with vaccination, and it is well-known that it took the genius of a Gœthe to enlighten the world upon the true measure of the genius of a Shakspeare.

Reviews, Books and Pamphlets.

Manual of Nervous Diseases and an Introduction to Medical Electricity. By A. B. Arnold, M.D., Prof. of Diseases of the Nervous System and Clinical Medicine College of Physicians and Surgeons, Baltimore, Md. With illustrations. New York: J. H. Vail & Co. 1885. pp. 170.

Being persuaded that the beginner in the study of the disease of the nervous system is not prepared to profit by the large and exhaustive treatises, the author of this excellant manual has brought into requisition his large experience as a teacher of this branch in the preparation of a text-book particularly adapted to the needs of the student. The result has been a manual well worthy of attention, and which may be calculated to fulfil the end for which it was written, *i, e.*, to instruct the beginner, and, at the same time, to encourage him to a more extended study of the subject.

The introductory chapter is devoted to the anatomy and physiology, and is designed particularly to draw attention to the recent and important accessions to neurology. Following this is a carefully prepared chapter on symptomatology. The medical uses of electricity is next taken up and Ziemsen's motor points are shown by several neatly executed plates. Throughout the remainder of the book the special pathology and therapeutics of the diseases of the nervous system are discussed in a thoroughly practical manner.

Bodily Deformities and their Treatment; a Hand-book of Practical Orthopædics. By Henry Albert Reeves, F.R.C.S.E., Surgeon to the Royal Orthopædic Hospital, etc. With twenty-eight Illustrations. Philadelphia: P. Blackiston Son & Co. 1885. Cushings & Bailey, Baltimore, Md.

The Analectic. A monthly Summary of the Progress of Medical Science. Vol. I. Edited by Walter S. Wells, M.D.

New York and London: G. P. Putnam's Sons. 1884. Cushings & Bailey, Baltimore, Md.

Transactions of the American Ophthalmological Society. Twentieth Annual Meeting, Catskill Mountains, 1884. Boston. 1885.

Transactions of the American Dermatological Association. Eighth Annual Meeting, held August 27th, 28th and 29th, 1884. Official Report of the Proceedings by the Secretary W. T. Alexander, M.D.

Annual Report of the Supervising Surgeon-General of the Marine Hospital Service of the U. S., for the fiscal year 1884. Washington: Government Printing Office. 1884.

Cocaine, and its Uses in Ophthalmic and General Surgery. By H. Knapp, M.D., Prof. of Ophthalmology in the Medical Department of the University of the City of New York. Reprinted from the Archives of Ophthalmology. Dec. 1884. With Supplementary Contributions by Drs. F. H. Bosworth, R. J. Hall, E. S. Keyes, H. Knapp and Wm. M. Polk. New York and London: G. P. Putnam's Sons. 1885. Cushings & Bailey, Baltimore, Md.

Miscellany.

Why Trousseau was Miserable.—Dr. Marion Sims, in his autobiography, gives the following interesting account of Trousseau: "Trousseau was one of the greatest physicians of the age—a man endowed with physical beauty as well as fine intellect, the philosophic physician, the classical literateur, the elegant teacher, the successful practitioner. He was without a rival. I had never known such a grand man who was purely a physician, and yet he was a very miserable man, and why? Had he not reached the highest distinction in his profession? Was he not exhibited as the highest authority in medicine all over the world? His lectures were translated into all languages, and then he was the leading practitioner, the great consultant, the fashionable doctor in Paris, and had accumulated a large fortune. Everybody spoke well of him, everybody admired him as a man; his private character was above all reproach; he had no children whom he could not recognize as his own. As the world saw the man they had the right to think and to see that he ought to be one of the happiest of men. True, he was not Court physician, but every other ambition of his life had been fully gratified, and yet he was unhappy, and why? His wife was an elegant and accomplished woman, of great beauty and fine intellect, but they were separated. He had a daughter, one of the most beautiful women in Paris, who married a man too much her senior. They were incompatible and separated. He had an only son who was a scapegrace. He was a gambler and everything else that was bad. His father was worried to death with his dissoluteness and foolish extravagance, and had to pay enormous sums of money to extricate him from his disgraceful orgies and gambling complications. He was married to a fine woman who ought to have made any man happy, but he neglected and made her miserable. . . . Trousseau had not seen his son for a long time before he died. About a fortnight or three weeks before this event, his son went to one of the gambling hells of Paris and lost all his money and more than he could pay besides. His poor father died soon after this, and his unworthy son saw a notice of his death in a London paper the next day, and I saw the tall, handsome, wretched man bending heartbroken over his good father's coffin in the Madeleine, whence he followed it to its final resting place in the Père la Chaise. We are happy or unhappy in this life as our children choose to make us."—*Med. Record.*

Dr. H. C. Wood on Treatment of Bronchitis.—It is not generally known that alkalies in large doses are amongst the most efficient of sedative expectorants. The citrate of potassium is much the most eligible for administering alkaline expectorants; of it half to one ounce should be given in twenty-four hours. The following prescription has been tested during four to five years, and found to be much the most reliable and efficient sedative cough mixture that I have ever used: ℞. Citrate of potash, one ounce; lemon-juice, two ounces; syrup if ipecac, half ounce; syrup enough for six ounces. Dose—Tablespoonful four

to six times a day. When there is a good deal of cough or any excessive susceptibility of the bowels to loosening medicine, paregoric should be added in small quantity. The ipeccac should be varied according to the susceptibility of the patient's stomach. Sometimes it can be advantageously substituted by tartar emetic. Usually two to three drops of such medication will establish free expectoration. Then the stimulant expectorants are required, or squills and seneca, the former being the more valuable, though I cannot affirm that I have often obtained positive results from their use, and think much of their reputation is based upon tradition and natural tendency of the disease to subside. Even squills is inferior to the mur. of ammonia. Like all ammoniacal preparations, this must be given at short intervals to maintain constancy of effect. The action of the single dose can scarcely last over two hours. Its acidity and disagreeableness may be somewhat covered by glycerine. In very large amounts all ammonia salts are capable of acting on the crasis of the blood as alkalis and causing great vital depression. The value of copaiba in chronic bronchitis has been long recognized, and it may sometimes be used with advantage in obstinate subacute bronchitis. When the "cold" in children is obstinate, "syrup of garlic" is very efficacious. But the stimulant expectorant whilst in my hands has almost replaced others of the class is the oil of encalyptus. It may be administered in ordinary cases of adults to the amount of about forty minims a day. Its taste is so pre-eminently disagreeable that it should be given in capsules, each of which may contain ten minims; or, if the patient prefer, two capsules of five minims each may be taken at a dose. The oil appears to be slowly absorbed and eliminated so that four times a day is often enough. In emulsion it is very apt to cause unpleasant eructations, but in capsules is usually well borne. Some stomachs will not tolerate it. Counter-irritation is very useful; the oil of amber, an old remedy, is especiallly valuable in young children who have so often marked nervous disturbance and a tendency to collapse, diluted with one to three parts of sweet oil, applied to chest upon saturated flannel; it sometimes acts very happily in allaying nervousness as well as internal congestion.—*Ther. Gaz.*

Ergot in Typhoid Fever.—*Dr. A. Grilliere*, in his inaugural thesis, noticed in the *Un. Medicale*, January 1, 1885, gives the following conclusions: Without being a heroic remedy it is a very useful one in the treatment of typhoid fever. Its effects are analogous to those of quinine and cold baths. It is operative especially in the congestive pulmonary and abdominal form by virtue of its influence over blood stasis and diarrhœa. It is antipyretic, its action in this respect being sometimes very rapid. It diminishes the frequency of the pulse and regulates the circulation. The ataxic and cerebro-spinal forms are surely modified by it. It can be employed during menstruation without fear of accident. The dose varies much according to individuals; with some it is necessary to give 45 to 60 grains a day to obtain a therapeutic effect; in others a much smaller quantity may occasion circulatory troubles. The vomiting which the first doses sometimes excites is to be feared as a rule only during the first two or three days; should it persist the ergot may be replaced by injections of ergotine. It may be added that as far as possible the drug should be given in fractional doses which permits better to watch the effect. There need be no fear of using it in children. The author cites 258 cases thus treated with a mortality of 22, being a mortality of 8.5 per cent.

Death of Dr. Septimus D. Jay.—Dr. Septimus D. Jay, a young and highly promising physician of Havre de Grace, Md., died in that place on the 14th of Feb. with cerebro-spinal meningitis after an illness of ten days. Dr. Jay was born near Aberdeen, Harford Co., in 1854. He graduated from the University of Pennsylvania, in medicine, in 1877, and has practiced his profession with signal success since. Recently his duties were very arduous and he had been attending a number of cases of cerebro-spinal meningitis. It is presumed that he contracted his illness in this way. Dr. Jay was a brother of Dr. John G. Jay, of this city.

Female Medical Students in Paris.—The number of female students inscribed at the Paris Faculty of Medicine shows a considerable increase, there being at the present time 78 upon the register, as against 45 last year, while 12 more are awaiting ad-

mission. Only 13 of the whole number are French, there being 47 Russians, 11 English, and 3 Americans. M. Beclard expressed his regret that most of the female students of foreign origin had been admitted without producing their degrees or the equivalent of them, and urged the Council to make this compulsory in the future. No decision was arrived at as to the admission of women as in and out students at the hospitals; but the preponderance of opinion seemed to be in favor of admitting them at the latter but not at the former.—*Lond. Med. Times and Gaz.*

Medical Advice by Telephone.—*Husband*—My wife has a severe pain in the back of her neck, and complains of a sort of sourness in the stomach.

Physician—She has malarial colic.

Husband—What shall I do for her?

[The girl at the "central" switches off to a machinist talking to a saw-mill man].

Machinist to Husband—I think she is covered with scales inside, about an inch thick. Let her cool down during the night, and before she fires up in the morning, take a hammer and pound her thoroughly all over, and then take a hose and hitch it to a fire-plug and wash her out.

Husband has no further need of this doctor.—*Leonard's Med. Journ.*

Treatment of Sick Headache.—*Dr. W. Gill Wylie*, of New York, has produced excellent results with the following method: So soon as the first pain is felt the patient is to take a pill or capsule containing one grain of inspissated ox-gall and one drop of oil of gaultheria, every hour until relief is felt or until six have been taken. Dr. W. states that sick headache as such is almost invariably cut short by this plan although some pain of a neuralgic character remains in a few cases.—*N. Y. Med. Jour.*

External Use of Chloroform in Labor.—*Dr. A. Svanberg*, of Sweden, (*Chicago M. J. and Ex.*, Jan., 1885) recommends to apply a piece of flannel saturated with chloroform and sweet oil, equal parts, to the skin below the umbilicus. The application may be renewed p. r. n. In from five to ten minutes the effect is obtained. The local application is designed to supersede inhalation. Dr. S. has successfully employed this method in retained placenta with *tetanus uteri*, transverse presentations with rigidly contracted uterus and escape of liquor amnii, and breech presentations with rigidity of the internal os. In certain of these cases the inhalation of chloroform was not sufficient to relax the uterine contractions.

Sponge left in the Abdomen after Ovariotomy.—*Dr. D. A. K. Steele* (*Chicago Med. Jour. and Exr.*, Jan. 1885), reports a case of ovariotomy in which the patient did well for forty-eight hours after the operation, but symptoms of pyæmia then appeared, and she died on the fifth day. At the autopsy a small sponge with a string attached to it was found in Douglas's *cul-de-sac* firmly imbedded in lymph. No hemorrhage had occurred, but general peritonitis had set in and the cause of death was quite apparent. But for the presence of the foreign body the patient would doubtless have recovered, and it seemed almost impossible that it should have been overlooked when the final count was made. *Dr. Parkes* said he was present at the operation, and he remembered the precautions that had been taken to guard against such an accident.

Medical Items.

The 79th annual commencement of the University of Maryland, School of Medicine, will be held at the Academy of Music on Tuesday, March 17th, at 12 o'clock, M. Prof. R. Dorsey Coale, A. M., Ph. D., will deliver the address to the graduating class.

The first essential in the intelligent use of the pessary, and for the avoidance of its abuse, is a correct diagnosis; and the second is an understanding of its action. Without these nothing but confusion, and probably injury, can follow.—*Bantock.*

Bigelow's method of relieving asphyxia from blood in the trachea, as related by Dr. Beach, is quickly to pass an elastic catheter through the tracheal wound, down the trachea beyond the obstructing clot and through forcibly inflating to dislodge the clot.—*Ex.*

Dr. James Owens Smith, an eminent New York physician, who won distinction in several yellow fever epidemics, died suddenly on January 30th from apoplexy.

Bromide of ammonia is recommended by Da Costa in the treatment of acute inflammatory rheumatism. It diminishes the tendency to heart complications.

Bartholow uses hypodermics of ether to tide over the crisis in typhoid pneumonia.

Dr. Wood, the inventor of the hypodermic syringe, died recently in Edinburgh.

The number of practitioners who have thus far studied in the New York Polyclinic as members of the class is 463. The attendance for the present session is 25 per cent. in excess of any former year.

It is reported that Mr. John McCullough, the tragedian, is in the incipient stage of a grave cerebral disease. Only the most judicious care will ever enable him to act again.

The last meeting of the New York State Medical Society was a more notable success than usual, says the *Record*, "for the Society succeeded in coming to an agreement regarding the bill to establish a Board of Medical Examiners."

℞. Vaseline, spts. turpentine, āā one ounce; carbolic acid, ten drops. Recommended as a certain cure for frost bite, by Dr. L. G. Doane, of New York.

Dr. James E. Baker, recommends in the *Med. Record* cocaine in phthisical cough. Five minims of the four per cent. solution, with a like amount of chloroform, were dropped upon an inhaler and thus taken at bedtime. In two cases of this kind he succeeded in giving the patients a better night and making them more comfortable than he had been able to do by any other mode of treatment.

The House of Representatives has passed a bill appropriating $200,000 towards an army medical museum and medical library building. It is to be erected on the Smithsonian grounds, Washington, D. C. The bill has not yet passed the Senate.

It is stated by the *Med. News* that Prof. Mallet intends, at the close of the session of this year, to resign the Chair of Chemistry in the Jefferson Medical College, Philadelphia, and that he will resume his professorship at the University of Virginia.

The American Neurological Association meets in New York, June 17th.

A Washington correspondent to the N. Y. *Med. Journ.* says: "Co-education of the sexes prevails here. At a surgical clinic at one of the hospitals recently there were four young ladies present with the class. The subjects for instruction on that occasion were three cases of fistula in ano and two of phimosis. The fistulæ were cut and the elongated prepuces duly abbreviated in the presence of the class, but the young women, it is said, have not since been regular attendants."

No less than thirty-eight State medical societies meet annually in this country, and issue a volume of Transactions. New York has two and all the other States one, except Nevada.

Mr. J. Greig Smith reports in the *Lancet* twenty-five cases of laparotomy done in the Bristol Infirmary, in the general operating room and without restrictions upon attendants, with but one death. *Listerism was observed in all its fullest details.*

According to the *Hospital Gazette and Students' Journal*, the University of Vermont offers its diploma to English medical men, without residence and upon a mere examination, for $30.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from Feb. 10, 1885, to Feb. 16, 1885.

Robinson, S. Q., Captain and Assistant Surgeon, from Portland, Oregon, to his proper station, Fort Spokane, W. T.

Kean, J. R., First Lieutenant and Assistant Surgeon, (recently appointed) assigned to duty at Fort Sill, Indian Territory.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service for the week ending February 14, 1885.

Guiteras, John, Passed Assistant Surgeon. When relieved at Key West, Fla., to proceed to Charleston, S. C., and assume charge. Feb. 11, 1885.

Kalloch, P. C., Assistant Surgeon. To report to Passed Assistant Surgeon Peckham at Wilmington, N. C., for examination for promotion. Feb. 10, 1885.

Glennan, A. H., Assistant Surgeon. Relieved from duty at New Orleans, La., to proceed to Key West, Fla., and assume charge. Feb. 11, 1885.

Original Articles.

REPORT OF TWO CASES OF TUMOR WITHIN THE CRANIAL CAVITY.

BY W. T. COUNCILMAN, M.D.,

Associate in Pathology Johns Hopkins University.

Among the cases of tumor formation within the cranium which have presented themselves at the autopsy table of Bayview Asylum were the following two cases, which offer some points of interest. It is to be regretted that the clinical history of the same is rather meagre.

Case I. A. G., woman, æt. 24; admitted to the insane wards of the Asylum September, 1882; died May 17, 1884. The cause of death was a pneumonia of the right lung with pleurisy on the same side. The chief pathological interest in the case was in the nervous centres. The skull was thin; scalp lightly adherent and pale. The dura mater was firmly adherent to the inner surface of the calvarium. At several points on the inner surface of skull small exostoses were found. On the inner surface of the dura mater, especially along both sides of the falx cerebri, small greyish nodules, varying in size from that of a pin's head up to that of a large bean, were found. On the dura, lining the base of the skull were similar nodules. These nodules were of a firm elastic consistency, and of a greyish color; they had caused deep indurations in the brain substance beneath them. There were also tumors of small size seated on several of the cranial nerves, notably one in the optic chiasm and on both of the auditory nerves. The left olfactory was also compressed by a tumor seated immediately over it. The principal tumors were seated on either side of the pons and upper portion of the medulla. The largest of these was on the left side, and represented a large, nodular, irregular mass of the size of a small hen's egg, which had displaced the corresponding lobe of the cerebellum above and to the left, and had pushed the pons and medulla, to which it seemed intimately adherent, over to the right. On the right side was seated a small tumor, which projected deeply into the pons and had forced this over to the left side above the place where it was pushed over to the right by the larger tumor. The cerebellum was very much compressed by both tumors and reduced to half its normal size. Both of the lateral ventricles were dilated, and contained about 100 c. c. of serum together. Along the choroid plexus of both sides, though especially on the right, there were seated small, pearly white nodules from the size of a pin's head up to that of a pea. The pia was hyperæmic. No tumors were found in the cord, which appeared to be of ordinary color and consistency. Further examination showed the tumor to be an ordinary psammonia which had developed in the dura mater. In every case the tumors were separated from the cerebral substance by the pia mater. Even the two large masses alongside of the pons could be shelled out with little trouble after they were hardened in Muller's fluid. Where the brain had been deeply indented by the nodules there was no destruction of the grey matter, which was merely pushed in before the growing mass. The nerves which were attacked by the tumors were all degenerated. From the great distortion of the pons and medulla, it was supposed that very evident ascending and descending degeneration of nerve tracts would be found. But the most thorough examination showed that all degeneration was wanting. In spite of the pressure exerted on both pons and medulla, by which the medulla, in places where tumor nodules on both sides had grown into it, was compressed to a width of little more than 1 c. m., nothing was destroyed. After the two tumors were removed, cross sections of the pons and medulla presented a most singular appearance. In some places the fibres of the pons were pushed up to a point in the median line, in others it could be plainly seen how the fibres of the pyramidal tract bent around a knob of tumor. The component parts of the medulla could scarcely be recognized by the naked eye, and all the fibres pursued an irregular and tortuous course. Nothing was destroyed, nor had the course of the fibres in any place been totally interrupted. This case is of much interest as showing the degree of distortion due to gradual compression that so important an organ as the medulla can withstand without any injury. Owing to the degeneration of the cranial nerves, caused by their involvement in the growth of the tumors, the patient was in such a condition that nothing could be learned from her. As was to be expected, she was blind, deaf, and

dumb. That the tumors at the base of the brain had caused no injury of the pyramidal tract is further shown by the fact that she had suffered no paralysis.

Case II. C. H., negro, æt. 40; for several years an inmate of the insane wards of the Asylum.

The body was large, slightly built, and badly nourished. The scalp was firmly adherent. The periosteum was thickened and removed with difficulty from the skull. The surface of the skull beneath the periosteum was rough and irregular. It was evident that there was a recent osseous development on the outer table of the skull, especially along the lines of the sutures. The dura was intimately adherent to the internal surface of the calvarium, which was found rough and irregular on its removal. The sutures were more evident than normal. On the outer surface of the dura mater were numerous small, firm tumor masses, which had produced erosions in the base of the skull. The largest of these small tumors were seated in the temporal fossa. In the falx cerebri, about midway of the corpus callosum, was a large tumor, which was on either side adherent to the brain. This tumor measured 7 c. m. from side to side, and 5 c. m. perpendicularly. It had not directly attacked the brain substance in any place, but this was pressed aside and in some places seemed atrophied from pressure. The ventricles contained more fluid than is normally present. The tumor was of firm consistency and of a greyish color. In the centre it was firmer, more opaque, and fibrous. On either side of the medulla were two large tumor masses, that on the left being larger than the right. These had somewhat compressed the pons, and were directly pressing on the crura cerebelli. On numerous cranial nerves, on the fifth on right side, on the left auditory, and others, were small semi-transparent grey nodules. On cutting through the lower portion of the medulla no degenerative change was apparent. In the cord there were several tumors, all of which were surrounded by nervous tissue. The most interesting of these was seated in the cervical cord opposite the place of exit of the second and third cervical nerves. This tumor measured 2 c. m. long, 1½ c. m. transversely, and 1 c. m. antero-posteriorly. It seemed to have developed in the centre of the cord, as it was surrounded by a narrow seam of white and grey matter. Here the capacity of nerve fibres to give way before pressure was more apparent than in the case of the medulla in the first case cited. The nerve fibres running around the tumor were in no place degenerated, nor was there any degeneration above or below, as must have been the case had there been any interruption. The ganglion cells of the cord were lying outside the tumor, and a few were enclosed in the peripheral cells. There certainly seemed to have been some destruction here, as many of the ganglion cells were found to be shriveled and atrophied. The roots of the spinal nerve ran around the tumor. Another small tumor, no larger than a No. 2 shot, was found in the cervical cord opposite the sixth cervical nerve. This was on the left side of the cord just outside of the anterior horns of grey matter. Two other tumors of the size of a small pea were found in the dorsal cord. Beyond a distortion of the grey matter, these did not seem to have done any harm. The growth was in every instance solid and compact, and had in no place the appearance of involving any of the nervous tissue in its mass. In addition to these tumors of the cord, small tumors were seated on many of the spinal nerves, on both the anterior and posterior roots. Here also the nerve fibres passing either through or around the tumors were not degenerated. Histologically the tumors in the last case were spindle-cell sarcomas, with here and there some bands of fibrous tissue. The peculiar calcarious degeneration around the vessels, leading to the formation of concentric calcarious masses, which has caused these tumors to be designated psammonia or sand tumors, were present in all the larger ones. The small ones were in general typical spindle-cell sarcomas. The largest tumor mass in the the brain had evidently developed in the falx cerebri. In its centre it was more fibrous than in the periphery, where it was composed almost exclusively of spindle cells.

The clinical history of the last case gives some interesting facts. The man was partly idiotic, and always lay doubled up in one corner of his cell. He could understand when spoken to. His movements were inco-ordinate to some degree, as evinced by his spilling his food in carrying it to his mouth. His strength was slight. When

taken hold and lifted to his feet he seemed not to have the power of balancing himself.

With a little help, to keep him balanced, he could stand, but when the hand was removed from his arm or shoulder he fell doubled up in a heap. Much might possibly have been learned from a close clinical study of the case, but the matter would have been complicated by the multiplicity of his lesions.

SPECIMEN OF STOMACH FROM CASE OF POISONING BY "ROUGH ON RATS."*

BY DR. WILLARD, OF PHILADELPHIA.

This specimen is presented for Dr. F. W. Coover, of Harrisburg, Pa., with the following history: The individual from whom the specimen was taken, was last seen in health between one and two o'clock, Saturday morning, May 3, 1883. About seven o'clock A. M., she was found in an unconscious condition, with two gas-burners in the room unlighted and turned on. On the floor and sofa beside her was some material that had evidently been thrown off from the stomach. I saw her at seven-and-a-half o'clock. She had been carried to her room, and was lying on her back in bed, her body extended full length. She was unconscious, and could not be roused. She threw her hands around, and pressed them over the abdomen. There was no spasmodic rigidity of the upper or lower extremities; she made no resistence when firm pressure was made over the stomach. Extreme pallor of face and upper lip. Mucous membrane of lower lip red and angry-looking. Pupils widely dilated, and not responsive to light. Eyeballs slightly congested. Feeble pulse—about eighty per minute. Respiration increased to thirty per minute. An involuntary discharge from the bowels had occurred. An emetic of sulphate of zinc was administered by the mouth, with but little difficulty, which was followed in a few minutes by free vomiting of a pint or more of slightly yellow-colored liquid, mixed with ropy mucus. The white of eggs, milk and whisky was given soon afterwards, and retained. After the emetic had operated, there was no retching or vomiting. About noon, some movements were noticed that indicated returning consciousness, but her symptoms showed increasing heart-failure. She would roll from side to side, and restlessness increased. She would slide down in bed. She had more discharges from the bowels, but no urine was voided. By two o'clock, she became conscious, and answered all question intelligently. She told me she had taken a teaspoonful of "Rough on Rats," dissolved in tea, shortly after midnight. That soon after taking it, she vomited, and from that time she had no recollection of what since had occurred. She complained of no pain, except dryness of the throat, which annoyed her greatly. She felt weak and sleepy, and wanted to get well, and took what was given her cheerfully. The stupor, however, increased, and she died comatose, without any convulsions or struggling, about fifteen hours after having taken the fatal dose. The post-mortem was made about fourteen hours after death. The body was that of a well-developed female, about twenty-three years old, weighing one hundred and forty pounds; *rigor mortis* well marked; all organs, thoracic and abdominal, healthy. Stomach removed, and contained about a pint of liquid, which appeared to be milk, eggs and whisky. The mucous membrane of the stomach was highly inflamed, particular around the cardiac orifice, portions of it seeming to be detached. The small intestines were distended with gas, the mucous membrane having more than its usual color. The colon and rectum were collapsed and empty. The bladder likewise was empty.

*Read before Philadelphia County Medical Society, December 17, 1884.

Points in Ovariotomy.—*Dr. D. A. K. Steele*, of Chicago (*Chicago Med. Jour. and Ex.*, Jan. 1885), emphasizes the following points in ovariotomy: 1. Always count the sponges used in operation. 2. Observe absolute cleanliness. 3. Peritonitis is not a contra-indication of either tapping or ovariotomy. 4. Cystic fluid left in the peritoneal cavity is dangerous and likely to cause pyæmia, but blood is probably innocuous. 5. A rubber blanket fastened to the patient with a central fenestra through which to operate is useless; small tin basins for the waste being preferable, as they can easily be changed. 6. Each case calls for special judgment and attention to every detail.

Lecture.

INSANITY.

(*Madness—Mental Derangement—Affectus Mentis*).

(Concluded).

A Lecture delivered before the Students of the University of Maryland,

By Richard McSherry, M. D.

Professor of Principles and Practice of Medicine, University of Maryland.

Causes of Insanity.—The predisposition to insanity may be inherited or acquired. That it may be inherited is obvious from the fact that it often runs in families; that it may be acquired is equally obvious from its occurring in individuals whose families are entirely exempt from it. Persons subject to vivid fancies, or strong impulses, who give loose rein to such fancies or impulses, may thereby acquire a predisposition to insanity. Perverted education, whether, by forcing the infant mind, or by educating certain faculties to the entire neglect of others, is one of many predisposing causes. Habitual yielding to evil emotions and bad passions, excessive indulgence of the passions, intolerance of moral restraint, etc., are obvious causes. Venereal excesses and masturbation are held to be among the commonest causes by physicians having charge of the insane. In fact, upon looking over the catalogue furnished by any of the insane asylums, you will see that vicious self-indulgence, whether venereal or of other kinds, is a common and potent cause of aberration of mind. Syphilis sometimes deposits a vitiated lymph upon the brain or its membranes. The immoderate use of nervous stimulants or sedatives, as alcoholic liquors, opium, tobacco, etc., predisposes to impairment of the mental powers.

Anger, fear, and all high excitements, no matter in what order; ambition, jealousy, the spirit of revenge; involve danger to the nobler faculties. War sends hosts of victims to mad-houses; religious excitement, and indeed all agencies capable of affecting the nervous system powerfully and irregularly, are so many causes of insanity.

Organic affections of the brain and its meninges are physical causes which are rarely or never absent in some degree in permanent insanity. Very often insanity is introduced by inflammation of these organs, which may disappear, yet leave the cerebral tissues permanently impaired, or more happily, may by its disappearance, admit of physical and mental restoration. We do not yet understand the essential nature of insanity, but we have sufficient reason to believe that it is in some way always associated with some disease, or perversion, of the gray matter of the brain.

Epilepsy is not unfrequently the cause or effect of different kinds of mental aberrations, and sometimes undoubtedly acts of great violence—as homicide—are committed in paroxysms of epileptic mania—from which the patient may soon recover and regain his mental faculties—forgetting entirely the paroxysm and its frightful results. Epileptic mania should, therefore, be placed under the same restraints as other forms of madness.

Diagnosis.—A correct diagnosis in insanity is of great importance, not only as regards treatment, but in a medico-legal point of view. The delirium of fever can scarcely be questionable under any circumstances, though I have known patients in fever to exaggerate an attendant flightiness into an apparent delirium, with some secret design, just as a man partially intoxicated, may, for some object, affect a greater excitement than he really feels. But, independently of fever, insanity may be feigned for various purposes. The plea is often set up to excuse or palliate crime. You are always liable to be called on as witnesses in such cases, and it is necessary that you should have some rules by which to distinguish between real and feigned insanity. The distinction is sometimes exceedingly difficult. But the insane man, if he will converse at all, is apt to deny insanity, while the feigner endeavors to make his insanity apparent. "It may be safely held that a person feigning insanity will rarely, if ever, try to prove himself to be sane, for he runs the great risk of satisfying others that he is sane—the conclusion he desires to avoid. But there is no other proof in general, that the insanity, (supposing other evidence to be strong) is real, than keen, eager attempts by the accused to prove that he is sane, and strong and indignant remonstrances against being held to be insane, although that would protect him against trial and punishment." (*Med. Juris.*, p. 630).

The sane man, you will observe, tries to *prove* himself to be insane; the insane man, on the contrary, tries to prove his sanity.

When an impostor tries to play the violent maniac, he raves most when most observed, and in the stillness of the night he is apt to sleep as other men. The true maniac often seems to live without sleep, and frequently raves as persistently through the night as during the day. The eye should be closely scanned. The impostor may distort his features, but his eye is calm; whereas the eye of the true maniac often exhibits a fearfully wild expression.

The history of the individual should be obtained as far as possible for diagnostic purposes. The sudden appearance of insanity, without fever or other evidences of phrenitis is open to suspicion; whereas a series of peculiar acts or expressions, antedating considerably the outbreak of mania, is in accordance with its regular approaches.

Such are the principal distinctive marks which will rarely deceive the intelligent physician. But sometimes protracted observation is necessary as the most skillful practitioner, even though he be an expert, may be incompetent to make a diagnosis in some cases from one or more brief interviews.*

Prognosis.—Mental alienation is necessarily a matter of great anxiety as to its issue. That which proceeds from some transient cause or condition is necessarily more promising than that proceeding from any permanent cause. Dr. Forbes Winslow, a very distinguished authority upon matters pertaining to insanity, says he has "no hesitation in affirming that, if brought within the sphere of medical treatment in the earlier stages, or even within a few months of the attack, insanity, unless the result of severe physical injury to the head, or connected with a peculiar conformation of the chest and cranium, and a hereditary diathesis, *is as easily curable as any other form of bodily disease, for the treatment of which we apply the resources of our art.*" This is certainly encouraging. Dr. Winslow, moreover, contends that patients should not be given up as hopeless because they have been long insane, that is, for years, as his own experience has shown that many of these cases are curable under a proper system of treatment. Insanity, in his view, *is the result of a specific morbid action of the hemispherical ganglia, ranging from irritation, passive and active congestion, up to positive and unmistakable inflammatory action.* This irritation or inflammation is in most cases susceptible of removal if taken early and properly managed. The *prognosis* is unfavorable if the disease is hereditary, or if there is want of symmetry or malformation of the head."

"In forming our prognosis, it is important to ascertain the educational training of the patient. Has he been in the habit of exercising great self-control? Has his mind been well disciplined? Has he kept in abeyance the passions, or have the motions and impulses of his nature obtained the mastery over him? He who has been taught to practice self-denial and self-control in early life, is, *cæteris paribus*, in a more favorable condition for recovery than he who has permitted himself to be the slave of every passion and caprice. Insanity, accompanied with criminal propensities, is said to be incurable. The prognosis is unfavorable, when the insanity is complicated with organic disease of the heart and lungs, with deafness and paralysis, in any of its forms. Great impairment of mind associated with paralysis is generally incurable." (*Br. Epit.*, II, p. 25). The same may be said of epilepsy, associated with insanity and of general progressive paralysis of insane.

Treatment.—The treatment of insanity is now for the most part confided to physicians who make this branch of the profession a specialty, yet it is important that you should have some acquaintance with it. In fixed insanity the rules of hygiene are of prime importance. It is now well established that the insane are best managed by kindness. The old infliction of whips, chains, dungeons, and even straight jackets, have yielded to gentle ministrations, and to providing the insane with such occupations and recreations as are best suited to their peculiar condition. Incipient or partial insanity has been made permanent and incurable by the harsh measures formerly in use. These patients should only be under so much restraint as may be necessary to prevent them from injuring themselves or others. They should always be under supervision, but such as may be least likely to be a source of irritation or offence.

* Dr. Buckham urges that when the plea of insanity is urged in extenuation of a criminal act, the party accused should be placed for some months in an asylum, in care of a competent expert, *before* trial. Deception would be thus made very difficult.—"Insanity in its Medico-Legal Relations."

As to the medical treatment, this should be directed according to the special condition of the subject. It is a question whether active depletion should ever be used with the insane, and if at all, in what form or to what extent. It is the fashion of the day to repudiate blood-letting, *in toto*, or at least general blood-letting, in all cases. Dr. Winslow does not concur with those who uniformly reject blood-letting. He says: "In attacks of insanity, where the symptoms are acute, the patient young and plethoric, the habitual secretions suppressed, the head hot and painful, the eyes intolerant of light, the conjunctiva injected, the pupils contracted, the pulse rapid and hard, and the paroxysm sudden in its development, *one* general bleeding will often arrest the progress of the cerebral mischief, greatly facilitate the application of other remedies, and ultimately promote recovery. In proportion as the symptoms of ordinary insanity approach those of phrenitis, shall we be justified in the use of general depletion." This rule seems to me to be perfectly sound, and in the condition above expressed, I should certainly resort to the remedy, though quite ready to admit that in the vast majority of cases general blood-letting is not safe nor admissible. Local blood-letting, as by cups or leeches to the temples, or behind the ears, may relieve heat of head and cerebral excitement in cases which would not bear general blood-letting.

I saw recorded some years ago an instance in which a violent maniac when being taken to an asylum, managed to get possession of a razor and cut his throat, intending to commit suicide. He only succeeded, however, in causing a large hemorrhage, the result of which was immediate recovery of his reason.

The prolonged use of hot baths (82° to 86° F.) for several hours daily, with cold affusion (60° F.) to the head, is a most valuable remedial agency. A hot bath before bedtime with cold to head, will often prove the most effective means of giving the patient a tranquil night's rest.

Purgatives are necessary in perhaps all cases of acute mania. Mercury may be used occasionally. The aloetic purgatives seem to the best for general use. Nauseating remedies are often valuable in calming down high excitement. If the stomach be free fro m disease, tartarized antimony may be used in broken dose, (gr.$\frac{1}{8}$ to gr.j) until nausea is produced and the general excitement is allayed. Chloral, bromide potass., verat. virid. aconite, &c., are often indicated.

When patients are very violent, it is not unusual to subject them the cold douche, or shower-bath, which is singularly powerful in bringing them into submission; but care must be taken that this remedy be not applied but for a very short time, as the prolonged action of the cold douche may produce serious injury.

Sedatives are admissible in insanity where there are no contra-indications, such as undue activity of the cerebral circulation, congestion, or paralysis. The sedative action of opium or morphia is eminently beneficial in many cases after the abatement of the primary excitement. The tinct. opii may be given advantageously with tart. antimony even in cases of cerebral conjestion when not acute. In cases of anæmia, or great debility, iron, quinine or alcohol may be given in combination with opium, or other sedative agents.

The physician should carefully examine in all cases whether there be any latent visceral disease. He may or may not get aid by interrogating the patient. One may complain of feigned pains, which he does not feel, and another may deny real pain. In cases of melancholy, particularly, it is necessary to investigate the condition of the liver, the stomach, the bowels, and in women,the condition of the uterine function. The remedies for melancholy proceeding from visceral disease, as of the liver, or womb, are clearly such as may remove the disease in those organs.

In insanity with paralysis, nux vomica, or strychnia, may exert a beneficial influence. Galvanism, or electricity in some of its forms, is often beneficial.

Insane patients sometimes obstinately refuse to take food or medicine. This may be a mere hallucination, but it often depends upon actual disease of the stomach. A blister to the epigastrium, frictions over the region of the liver, with a dilute solution of nitro-mur. acid, and the warm bath, may overcome this obstinacy when it is due to gastric irritation or inflammation. Otherwise it may be necessary to introduce forcibly small quantities of milk, or soup, into the stomach of the patient by injection, to prevent him from starving.

The paroxysms of *puerperal mania* are

sometimes best tranquilized by the inhalation of ether or chloroform.

These general rules for the treatment of insanity may be sufficient for your guidance in practice, but it is according to the general experience of the age that insane patients should be sent to proper asylums, where systematic treatment can be fully carried out.

In the predisposed, the prophylactic treatment should be entered upon early in life. The physician is rarely called upon to direct this, but if he should be, he is to remember that the mind, like the body, may be strengthened by judicious exercise, or may be impaired by excessive toil. Education should be directed to strengthening the mind rather than to *cramming*, and thus *impairing* it, in accordance with the custom of the day. And the moral faculties should be cultivated *pari passu*, with the intellectual. Faults of temper should be judiciously, not violently, corrected from infancy; and the child should be taught as his mind expands to keep evil emotions and bad passions under control. I think that with a well-directed education, and under circumstances made favorable by care, insanity could be warded off in nearly all cases. A person predisposed may do more to save himself, when convinced of the necessity of self-control, than can be done by others. But the physician, or psychologist, may give rules for the preservation of the mental, as he may, for that of the bodily health, which would otherwise be unknown to the individual liable to disease.

Clinical Notes.

THE USE OF WATER IN COLLAPSE OF CHOLERA.

Dr. J. Stinson Harrison, of Washington, D. C., writes: In your JOURNAL of February 14th, you give the proceedings of the "Medical Society of the District of Columbia," in which it is stated that Dr. A. F. A. King gave a brief outline of the course of treatment he should pursue should a case of cholera occur in his practice during the coming summer. Among other things, he says: "Should the case progress to the stage of collapse, I should give nothing but water until reaction commenced," etc. In confirmation of Dr. King's views on this subject, which are quite out of the common course of procedure in this stage of the disease, I wish to call attention to two cases which came under my personal observation several years ago, one in St. Louis, during the prevalence of cholera in that city, the other in north Louisiana.

The first was that of a young man about 23 years of age. He was attacked rather suddenly with choleraic diarrhœa, which was treated in the usual way at that time, by astringents, opiates, etc., but without any apparent benefit. He began to sink rapidly on the second day, and collapse seemed inevitable: thirst was extreme, and every symptom indicated a speedy and fatal termination; his constant cry was for *water*, *water*, *water*. I told his friends that, as he would most certainly die that night, my advice was to gratify him fully by giving him all the cold water he desired, they did so. I left him, fully expecting to find him dead next morning; but to my great surprise and gratification, when I visited him again, I found him much improved; every symptom was favorable, and continued so, until he finally recovered. In this case, *cold water liberally administered*, seemed to be an important factor in the means of his recovery, probably in *supplying the waste* of the water of the blood, upon which the intense thrist depended; for the demand for supply, indicated by the extreme thirst, was just in proportion to the loss of the watery portion of the circulating fluid. And by absorption, or in some other way, the water seemed to supply the loss, as reaction occurred in a few hours after the patient commenced drinking it largely.

The other case was a German woman in St. Louis, Mrs. K. F., æt. 44 years. She was attacked violently; in a few hours had cramps, vomiting and copious *rice water* discharges. When first called to see her, I found her in, at least, a "semi-collapsed" state; pulse almost imperceptible; surface cold and clammy; eyes sunken; features contracted, and even the tongue gave the sensation of coldness. I did what I could for her, but nothing seemed to be of any service. Thirst in this case also was extreme. But instead of desiring water she called for *beer—lager beer*.

As I had no hope of her recovery, I advised her husband to let her have all the beer she wanted.

I saw her take her first drink of, at least, half a pint, which she swallowed with the

greatest avidity, and to my astonishment *retained it.* I left her with the "*beer prescription*," *ad libitum*, supposing, of course, she would die in a few hours.

The next morning, however, in making my early calls, I stopped at her residence, and to my great surprise found her comparatively comfortable and greatly improved in every respect. She convalesced rapidly and soon recovered.

Now, while I am no advocate for beer drinking in health, I am compelled to believe that in this instance *lager* saved my patient. I will leave it with you, Messrs. Editors, to explain its *modus operandi*.

SPRAY IN OVARIOTOMY.

Dr. John Homans, of Boston, writes: The following is an extract from a recent work by Dr. Emmet (Emmet's Principles and Practice of Gynecology, p. 715): "In this country I do not know of any prominent operator who now employs the carbolic acid spray." This statement implies that the writer is not persuaded of the value of the spray in ovariotomy. My own experience has led me to an opposite opinion. Indeed, I should not like to do a laparotomy for any purpose without the antiseptic spray. I have been led to this conclusion by the results of one hundred and eighty-three cases of removal of cystic ovaries, of which I have lost only twenty-one, but more especially by the result of the last one hundred of these cases, only ten of which were fatal, while thirty-eight were consecutively successful. I feel that to omit the antiseptic spray would be to deprive the patient of one of the ready and efficient elements of success.

As I can hardly hope for much better results than those I have cited, and being quite content to let well enough alone, I shall hesitate before disturbing my present plan of operation by giving up a detail to which I attach much importance.

A DIURETIC MIXTURE.

Dr. Alexander L. Hodgden, of Farmwell, Va., writes: I have found the following combination, ℞ Extract apocynum cannabinum, fluid, ʒi; extr. belladonnæ, fluid. ♏xij. M.—valuable as a diuretic given in the dose of six drops every hour until effect is produced, or eight doses have been taken, especially in œdema from pregnancy. I have given it as directed above, or in œdema from pregnancy, six drops of the same three times a day for three or four days; some water should be taken with each dose. The belladonna outside of any other action seems to be very valuable in checking the secretion of the skin, which materially aids a diuretic action. I have never seen the combination before mentioned, in print, nor have I heard of its being used by any person excepting myself. I consider it very good and would like the profession to have the benefit of the same through the medium of your JOURNAL, if, after a trial of it, you think it merits a place in that paper.

Correspondence.

Editors Maryland Medical Journal:

I am under very many obligations to you for the number of the MARYLAND MEDICAL JOURNAL containing your strictures upon my "Open Letter," which appeared in the last number of the *North Carolina Medical Journal*.

I hardly think I deserve to be so severely handled, because, I do most honestly assure you, my object in writing that letter was not to injure the fair name of the medical schools of Baltimore, or any of her citizens, but to advance, to the best of my poor abilities, the real interests both of the people and physicians of North Carolina, and if in my power to do this, I have wounded or offended any one I am very sorry for it. I did not mean to reflect upon the character of Dr. Tiffany either as a gentleman or as a physician, but I did think that when he wrote that preparatory study was not necessary, he should have impressed upon the man the paramount importance of thorough preparation before entering upon the solemn obligations of a physician. If he had done so, the man would not be now practicing medicine; but I will reply to Dr. Tiffany's letter in the *North Carolina Medical Journal*.

If I had been in possession of the same facts with respect to the schools of Philadelphia or New York, I most certainly would have written Philadelphia or New York, but the facts related to Baltimore, consequently I wrote Baltimore. I am not in the habit of calling an old hat by any other name, unless it be upon the head of a female, and then, owing to the very uncertain

and obscure diagnosis, I might be induced to call it a *bonnet*.

The man to whom your editorial first refers, professes to be a graduate of the Washington University. I have never seen his diploma, and cannot say that he has one, but I have no doubt he has, as others have seen it. The other one mentioned went on to Baltimore year before last, without any preparation whatever, staid three months, then came home a "full fledged doctor in his own estimation," since which time he has been engaged in the practice of medicine, and resorts to all the crooked ways and low down tricks of the most unprincipled mountebank.

He does not claim to have a diploma (and you had no right to draw any such inference from my letter) but he does claim the University of Maryland as his alma mater, and she must be his mother since, for *three long months* he sucked medical knowledge and inspiration from her plethoric teats, and from no other source. And now I hold that the University of Maryland should prescribe for his irregular ways and for his excessive flatulence, and send him a bottle of Horlick's or Mellen's Food for Infants, because the child is really too young to wean, being only *three months old*. And if she is much interested in her offspring (legitimate or not) she might send down the janitor, too, to sit beside his cradle and warble in dulcet tones that lullaby so dear to every maternal heart—

"Hush, my baby, lie still and slumber."

for I tell you the infant is a puny child, and needs a mother's watchful care.

I did not know that Baltimore was especially tender upon this subject, as you intimated in your "editorial," and if my probe has touched too heavily I hope you will pardon me, because I was not making any effort in that direction, but I was making a feeble but honest effort to rid my State of a very foul old ulcer; and while trying to cleanse it, if by chance I fell upon two Baltimore grubs, as a surgeon, I know you will excuse me for trying to flirt them out of said ulcer, even though the execution may have been bungling.

You refer to my "open letter" as "slipshod." While I do not regard the expression as elegant, it does not matter, if you be as true phyicians as I take you to be, you will believe me when I assure you that my ardent desire has always been to do right, and to elevate the standard of our profession so far as in my power lay.

As to the proofs you call for, they shall be forthcoming in the February or March number of the *North Carolina Medical Journal*.

I am very respectfully yours,

R. L. Payne, M. D.

Lexington, N. C., Feb. 17, 1885.

Society Reports.

CLINICAL SOCIETY OF MARYLAND

STATED MEETING HELD FEB. 6, 1885.

(*Specially Reported for the Maryland Medical Journal.*)

The Society was called to order by the President, Dr. B. B. Browne, at 8.30 P. M., Dr. Jos. T. Smith, Secretary.

The first paper of the evening was read by *Dr. A. C. Abbott*, entitled,

A CONTRIBUTION TO THE PATHOLOGY OF MALARIAL FEVER.

Dr. Abbott reported two cases of the comatose form of malarial fever, which, upon post-mortem examination, presented most interesting conditions of the brain, spleen, liver and kidneys. The cortical portion of the brain was of a dull chocolate color, forming a most marked contrast to the white matter.

The liver was enlarged, congested, and of the classical bronze color described by writers upon this affection.

The spleen was enlarged, diffluent, intensely congested, and black in color.

The kidneys, in case first, were but slightly congested, and presented no evidence of chronic interstitial change. In the second case the capsule was partly adherent and the consistency of the organ somewhat greater than normal. Microscopic examination of the organs revealed a large amount of pigment, occurring in granules and in masses, and seen in a variety of forms.

The most interesting change was that noticed in the red blood-corpuscles of the brain and spleen. They were seen to contain a small round hyaline or finely granular body, in size about one-third the diameter of the corpuscles in which it was located. These bodies were marked by a deposit of pigment granules, which in most cases

showed a tendency to a circular arrangement, but in many instances were grouped together in figures of various shapes. These bodies stained faintly but distinctly with the analine dyes, as was plainly seen by the use of $\frac{1}{20}$ homogenous immersion lense with the Abbey condenser and the diaphram drawn out, thereby rendering the color-picture more apparent.

In most cases these hyaline bodies were enclosed in red blood-corpuscles, but in some instances they were found free in the capillaries. The normal color of the corpuscle infected by these hyaline bodies was not changed, as was seen in sections hardened in Müller's fluid, and examined in both water and glycerine.

In the liver the absence of these hyaline bodies was noticeable, but here the pigment was found in great quantities embodied in large protoplasmic masses, which entirely filled the lumen of the capillary in which they were located.

It was also seen that in the kidney *none* of the hyaline bodies were present, but pigment granules and masses were irregularly distributed throughout the organ, and were encased in protoplasmic masses, similar to those referred to in the liver.

Arguments were brought forth in favor of the small hyaline bodies referred to in the brain and spleen, being micro-organisms, as also was the opposite side of the question ventilated.

The writer thinks it possible that these bodies may represent a phase in the evolution of the parasite described by Laveran and Richard as occurring in the blood of patients suffering from the comatose form of malarial fever, although nothing is claimed as to their exact nature.

Microscopic examination of perfectly fresh material, from a large number of malarial cases, have been made by the writers, with *negative* result as to the presence of any bacillus micrococcus or any other form of micro-organism.

Dr. G. M. Sternberg said we have but few careful records of the pathological appearances in cases of this kind. The chief interest here attaches to the hyaline bodies; and the pigment is found only in malarial poisoning. The cases were truly those of malarial pernicious fever. In Rome it was observed that the comatose condition occurred in those supposed to be convalescent. As to the hyaline masses seen, it is an open question whether or not they are parasites; he thought it is likely they may be. It is important to note the entire absence of the bacilli, at least none were found in the many examinations.

Dr. N. G. Kierle thought a series of cases had been set forth which are found at certain seasons, but not consecutively. The cases can be diagnosed by the liver alone; it is of a bronze color, like that of new bronze gas fixtures; the spleen is like blue-black ink in color. He thought death took place by the way of the kidney; the kidneys were found congested, and the urine showed albumen and granular casts. Uræmic coma is more active in its nature; there is sterterous breathing with a distressed look; while in malarial coma the patient is quiet and has not the look of distress. He had found in one specimen corpuscles, with black dots, in the urine.

Dr. I. E. Atkinson was much interested in the subject. Clinicians say that pernicious malarial fever is a disease of brief duration, and it is the popular belief that a patient will not survive the third attack. Authors differ as to their definition of pernicious fever. He had noted some cases in which the fever gradually increased, and intense coma would set in, and at the end of five days the patient would die. He had seen Dr. Abbott's case. A slow gradually increasing coma in such cases is not given by authors; and he did not think any authorities give the history of a pernicious fever with a gradually increasing coma. It is likely we will realize the fact that the pernicious fevers are not as fulminating as we have been taught to believe. He was sure that many forms of disease are classed with pernicious fevers simply because they had uræmic coma. We have not yet a good arrangement of pernicious fevers.

Dr. J. C. Hemmeter remembered Dr. Abbott's case. The urine was very dark colored. Much light might be thrown upon many of these cases by a careful microscopical examination of the blood during life. The bodies found could hardly belong to the algæ, as they have not been observed to act as such. A chemical examination of the pigment might throw light upon the cause of these troubles.

Dr. S. T. Earle said most of the cases of pernicious fever he had seen had died within forty-eight hours. The temperature was usually about 104°, the highest he had

noted being 106°. Nothing that was done seemed to have any influence upon the course of the disease; quinine and mercury were used without any result. The cases have been mostly amongst negroes who lived near a swamp.

Dr. C. W. Mitchell mentioned the case of a man who had been brought into the hospital in a comatose condition, but who under treatment recovered; a neuritis, however, remained, for which he was treated; he finely died in a second attack. In reply to a question from Dr. Robt. Johnson, Dr. Mitchell said that a solution of the muriate of quinia and urea had been used hypodermically, in twenty minim doses, which reduced the temperature from 106° to 100°.

Dr. W. T. Councilman said special attention had been given the kidneys, and sufficient changes had been found to account for the albuminuria during life.

Dr. A. B. Arnold though albuminuria not reliable, as it may also be found in certain forms of heart disease. In the cases of congestive fevers he had seen the condition come on at once.

Dr. L. McL. Tiffany said he had heard a number of cases mentioned during the evening, but they did not coincide with the one noted in the paper. He did not think the second case spoken of by Dr. Abbott agreed with the accounts of pernicious fever, and as albumen and casts were found in the urine, he could not agree with the diagnosis. Such a case, with a temperature of 101½°, and lasting for seven days, is at variance with the accounts given by all authors. It might be a case of kidney disease, occurring in a person suffering from malarial fever, but not one of pernicious malarial fever.

Dr G. M. Sternberg thought there were two classes of pernicious malarial fever. In one the coma came out at once, and was directly caused by the malaria, in the other the coma was not the immediate result of exposure, but showed itself after the fever had lasted sometime. Possibly kidney trouble had something to do with the coma.

Dr. W. T. Councilman thought the diagnosis could be sustained by the anatomical conditions present, all of which showed the case to be one of pernicious fever. No doubt there was kidney trouble.

Dr A. C. Abbott said in fifty-one cases examined who had died of pernicious fever, twenty were found to have kidney trouble.

Dr J. W. Chambers had seen one of the cases noted by Dr. Abbott. The post-mortem showed a bronze color of the liver and congestion of the kidney. No urine could be found. The cases seemed to show how dangerous a complication malaria is with those suffering from kidney disease.

Dr. W. H. Norris said that in 1862 a large number of troops had malarial fever, and those in whom it assumed the pernicious form died in forty-eight hours. He thought the diagnosis in the case of Dr. Abbott at fault.

Dr. I. E. Atkinson thought from an examination of recorded cases one would be led to think that pernicious fevers ran a definite course, but may there not be other forms of pernicious fever than those laid down; and may not this case of Dr. Abbott's go to show that such is the fact. In malarial fever there is a strong tendency of the kidneys to participate. A vast amount of fatal disease has its origin in malarial fever.

In reply to a question from Dr. Brune, Dr. Atkinson said he did not regard albumen as vitally important as even in health at times organized elements may be found.

Dr. E. G. Waters thought the kidneys were chiefly at fault. He had seen many cases of malarial fever, and in those who died in coma the kidneys were found engorged. The fulminant cases were uniformly fatal. In no case were the kidneys regarded as as an element amongst the congested organs.

Dr. W. T. Councilman read a paper upon

TWO CASES OF TUMOR WITHIN THE CRANIAL CAVITY, WITH SPECIMENS.

(See this number of JOURNAL, page 331.)

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD JANUARY 26TH, 1885.

(*Specially Reported for the Md. Med. Journ.*).

The meeting was called to order at 8.45 P. M. by the President, DR. J. T. SMITH, DR. G. HENRY CHABOT, Secretary.

A CASE OF CONVULSIONS FOLLOWED BY DEATH.

Dr. Rohé reported the following case: His attention was called to a patient at

Bayview Asylum about forty years old, whose temperature was elevated about one degree; patient was stupid and hard to arouse; urine was examined and no albumen found. On Friday last had convulsions and died shortly after. On post-mortem examination to-day he was found to have granular kidney. The urine was not examined microscopically. The case was of interest on account of being so obscure.

DISCUSSION.

Dr. Waters said he was called in some-time ago to see a man in convulsions; his wife said she could not arouse him out of the stupor. Dr. W. examined the urine, found no albumen, and specific gravity normal. About six weeks later was called in again; found the patient in convulsions; his wife said the attack commenced with a loud exclamation. He then made up his mind that the patient was suffering from epilepsy.

Dr. I. E. Atkinson said that such cases often prove to be contracted kidney. The absence of dropsy is marked, and the specific gravity is usually low. These cases are not uncommon. He has two such cases at present.

CASE I.—Was called in about two weeks ago to see a man about 40 years of age; pulse 110 or 112; temperature elevated about one degree; his urine contained tube-casts and a slight trace of albumen; since has not been able to detect any albumen. Patient is portly and has slight cardiac hypertrophy. He is always nervous and agitated. Specific gravity of urine has not been above 1006.

CASE II.—This patient was taken with epistaxis and feeling of oppression about the heart. Specific gravity of urine 1020; found crystals of uric acid, also tube-casts, but no albumen; has no dropsy. Dr. A. thinks this a case of granular kidney. These cases are very common but often escape our notice. Convulsions are more commonly associated with defused nephritis.

Dr. Biedler opened the subject for discussion by reading a paper entitled

EPIDEMIC CHOLERA,

of which the following are the most important points discussed: He said as cholera had made its appearance in Europe in epidemic form, we ought to prepare, in case we should have an epidemic here, by building a home or hospital in which to treat and isolate the disease. The present condition of many of our streets, cesspools and sewers are such as rather to invite than to prevent the disease. He could not see a better plan than to have a number of sanitary inspectors, each inspector be given a certain locality to look after. We cannot give too much importance to clean and dry cellars, well ventilated closets, and plenty of pure air to inhale; and we should have a quarantine of thirty days when a vessel arrives from an infected port. Dr. Biedler also mentioned the history, post-mortem changes, and treatment. Brown-Sequard says the most efficient remedy is hypodermatic injections of morphia with atrophia. He also says this will prevent an attack.

DISCUSSION.

Dr. Rohé stated that quarantines as at present enforced are probably inefficient. Under a proper quarantine system there would be no need of a longer detention of passengers than five days from the appearance of the last case.

Dr. Arnold said cholera observes the same laws as other diseases, each invasion being less severe than the previous one. In 1849 he thought it was mild. The diarrhœa was easily checked by keeping the patient in the recumbent position and giving opium. He had cases of congestive intermittent fever that were very hard to diagnose from cholera.

Dr. Erich said he had seen eighteen or twenty cases; thinks quarantine the best method to prevent it. We cannot clean a large city like Baltimore so that the germ cannot find a foothold. We can prevent it entering the system by not eating any decomposing vegetables or fruits. Everything should be well cooked, and we cannot be too careful of our drinking water. Thinks that the decrease in the disease is due to improved drinking water. When the patients do recover they recover slowly, as from typhoid fever.

Dr. Pennington thinks the cholera poison enters by the lungs.

Dr. Hammond also hold this view.

Dr. Waters mentioned a case where some clothes were thrown from an infected ship and floated ashore; the cholera started from this point.

Dr. Biedler said he was surprised that anyone was opposed to quarantine. Clothing and all material used by patients should be burned. Thinks the poison enters the system through the stomach in the majority of cases.

The discussion was then closed.

Dr. C. H. Jones said he had a letter written by a member of the Association (Dr. Jas. A. Steuart) endorsing a patent medicine, and he asked that the letter be given to the Committee of Honor, and that they be requested to investigate the matter.

Dr. Waters gave notice that he will move to amend Section 1 of By-Laws by making the hour of meeting 8 o'clock instead of 8.30.

On motion, the Association then adjourned.

Excision of Larynx.—The lastest records are very unfavorable, and seem to lead to the conclusion that total removal of this organ is hardly a justifiable proceeding. Mr. T. Holmes published a fatal case in the *Journal* of Oct. 25th, and the operation has been performed with a like bad result in each instance by Mr. Jordan Lloyd, of Birmingham, and Dr. McLeod, of Calcutta. Zesas has lately published a table of no fewer than seventy instances in which the larynx was removed by Billroth, in which it is shown that twenty-eight patients died in the first fortnight and seventeen before the end of the year; and that in twelve of the surviving patients the dis ease, which in most of the cases was carcinoma, had recurred. Partial excision of the larynx seems to be a much less serious operation, and in the opinion of Hahn, of Berlin, is to be preferred to total extirpation, even in cases of cancer when the disease does not involve more than one side of the organ. Relapse, it is stated, does not occur more frequently after partial than after complete removal for cancerous diseases; the functional disturbance after the former proceeding is much less and the patient in most instances is able to dispense with the use of the cannula,—*Brit. Med. Jour.*

Dr. Louis Elsberg, Professor of Laryngology and Rinology in the N. Y. Polyclinic, died in that city on the 19th. Dr. Elsberg was well-known throughout the medical world as an able specialist.

Editorial.

Annual Message of Mayor Latrobe.—This document, a copy of which has been handed us, deals with several subjects of vital importance to the health and welfare of this community; and, as it embodies the views and recommendations of the health officers no less than of the chief magistrate of the city, is worthy of attentive consideration at the hands of the profession. In commenting upon the death rate the mayor quotes the statement of Sir J. W. Bazalgette, C. B., President of the Institution of Civil Engineers of England, that "the city of Baltimore stands third in regard to health," Christiania and London alone preceding it. The rate in Baltimore for 1882, 1883 and 1884 was 21.81, 22.93 and 20.27 per 1000 respectively. If the statement of the eminent authority quoted were based upon the official census of Baltimore we would be disposed to accept it as a compliment worthily bestowed, but we well know the deceptive figures given forth by the Health Department of this city based as they are upon self-assumed data of the Health office, which have been amply proven unreliable in the lectures of Dr. Billings, delivered at the Johns Hopkins University last year. The expenses of the Health Department during 1884 were $67,209.54, having been $190,-711.82 in 1883, the difference being due mainly to the epidemic of small pox which prevailed in 1883 and carried off 653 persons, only one death occurring from this cause in 1884. The necessity for some system of sewerage is again brought forward and urged as it is every year—and we hope will be until the City Council takes some steps in the premises. Whilst nothing can be done without the authority of the Legislature for the issuance of bonds, it is urged that plans might be considered and the final consummation thus be brought nearer to realization. It is suggested that a sewer tax would be cheaper than cleaning the 80,000 cesspools, and the interest on the cost of construction could probably be thus met in full. The long needed morgue is also recommended with the suggestion that it might be connected with one of the station houses and placed in charge of the police and economically administered. The completion of the building at Bayview Asylum for the reception of the indigent insane of the city is announced. This will furnish

quarters for many of the incurable inmates of the crowded Spring Grove Asylum, besides reducing the expenses nearly one-half. The crowded condition of the jail, affording a constant menace to the health of the city, is adverted to, and the recommendations of the Health Officer for "the removal of all pumps,the abatement of nuisances connected with slaughter-houses within the city limits, the want of an ordinance requiring vacant lots to be properly drained before being built upon, the importance of preventing the sale of unsound meats or spoiled fruit and vegetables and all articles of food not in fit condition for human consumption, a liberal provision for cleansing the sewers and having all inlets thereto properly tapped," etc. The registration of births is urged upon medical practitioners in order that correct vital statistics may be obtained, but we fear not much will be accomplished towards this result without the adoption of compulsory measures. Unfavorable comment is made upon the discrepancy between the births reported during the year—1884—and the number of vaccinations—1,567, "an average of 156 to each of the ten vaccine physicians," and this notwithstanding the compulsory law upon the statute book. On the whole the medical and sanitary aspects of the report are highly satisfactory, and it only remains for the Council to carry out the Mayor's wise recommendations and thus fulfill the highest duty which they owe to their constituents.

Dr. Thomas Keith on Antiseptics in Abdominal Surgery.—The dramatic scene at the London International Congress when Dr. Thomas Keith arose, and in the midst of the vast hushed audience, declared his abandonment of the spray in ovariotomy, and the reasons that had impelled him thereto, remains still fresh in the memory. It was the first great blow Listerism had received, and to this more than to any other one thing is due the decadence of the great antisepticist's special method, the spray, etc. For the success of Keith before that had been phenomenal, and it was adduced everywhere as irrefragable proof of the value of Listerism. Keith now again comes forward, and in the *Brit. Med. Jour.* of January 31st, declares his increased conviction of the truth of his earlier views as to the uselessness, nay harmfulness, of the carbolic spray in abdominal surgery. It may be well to give the grounds for his belief. He states that he has now had thirty-eight supra-vaginal hysterectomies, with a mortality of three. He has performed double ovariotomy for disease sixty times. He has opened the abdomen for removal of uterine or ovarian tumors five hundred and fifty times. Now of his thirty-eight hysterectomies six were performed under the spray, one of which died, death being preceded by hæmaturia, albuminuria and acute mania. Of the remaining thirty-two, two died from exhaustion. He declares that there is nothing in all his work that has so thoroughly broken down with him as the carrying out of the so-called "perfect Listerism" in the surgery of the abdomen by means of the carbolic spray. "I expected much, but have got nothing after years of vexation and disappointment, and I am now very much where I was before I ever heard of it." The result of ovariotomies done, in the Royal Infirmary, are particularly striking. Under the spray the mortality was three in twenty-one, or one in seven, whereas after the abandonment of the spray there were only two deaths in thirty-eight, or one in forty-four, including cases done by the assistant as well as himself, and neither of the two was from septicæmia.

We cannot do better, perhaps, than quote verbatim the conclusion of Dr. Keith's paper:

"Those who teach that the carbolic spray in the abdominal surgery is anything else than an useless ceremony, can make of these results what they may. One thing is, however, certain: both ways cannot be the right way. If a "single germ" getting into the abdomen during an operation, play the mischief it is said to do, then few cases, done in the old way, ought to recover at all; whereas in the heart of the very surgical hospital, and almost next door to where Prof. Chiene tells us that the atmosphere is laden with death-carrying germs, less than one only out of every forty have died after ovariotomy. What is one to make of al these things? If Mr. Thornton gets a fatal result in every third case where he removes a uterine fibroid, with his complete and perfect Listerism, spray, and all the rest of it, am I to go back to these ways when I get one of sixteen without them? By no means. The antiseptic principle which I believe in, as much as any one, can be carried out by simpler means than these; and for myself I have almost gone back to the boiled water and soda of twenty years ago. It is, unfortunately, a sad fact that ever since surgery began the great evil was done by the surgeon himself. It was the willing and tender, though unclean hand, that carried most of the poison into the wounds. It is to this that Lister has put a stop. With a proper antiseptic a surgeon is now made to be clean in spite of himself; is compelled to have safe sponges; safe ligatures; clean instruments, and above all, clean fingers. If one be

careful—and few are careful enough—one may do all this, as Mr. Lawson Tait does, with boiled water and soda. Some such preventions are essential; beyond these, with ordinary care, we need not disturb ourselves much as to what is in the air. Yet it was a pleasant doctrine to believe in to put the whole blame of a bad result, that should not have been a bad result, upon some indefinite unknown something in the air—something beyond ourselves. It was no fault of ours, it could not have been helped. Everything was done that could have been done. I fear we are all apt to blame place, persons, things, accidents, circumstances—anything you like under the sun—rather than ourselves.

Dr. Payne's Letter.—We most heartily recommend Dr. Payne's zeal in behalf of his State and profession and give him now, as we did before, all credit for honesty and sincerity of purpose. What we insisted upon was that in charges involving the reputation of reputable medical schools the exact data upon which they were based should be given.

With reference to the facts which he now adduces: The Washington University ceased to exist some nine or ten years ago, and as to the character of its requirements we are not informed. It is manifestly absurd to hold the University of Maryland responsible for the lack of acquirements and the misconduct of a man who spent *only three months* within its walls. Had the individual in question received the diploma of the school we could see some justice in it. The standing of the University's *graduates* has been well attested in North Carolina, where of the large number who have presented themselves before the State Board of Examiners, *not one* has yet been rejected. Of this fact Dr. Payne certainly cannot be ignorant. The construction we put upon Dr. Payne's words "returned a full fledged doctor in his own estimation," viz: that they implied that he had received a degree here, is the one which we still think most readers of his letter will give them. We regret to add that we do not think Dr. Payne will strengthen his cause much by adopting the purile style of a portion of his present communication.

Resignation of the Secretary of the State Board of Health of West Virginia.—Since the organization of the State Board of Health of West Virginia, in 1881, this body has achieved the distinction of being one of the most efficient health organizations in this country. This Board of Health has done a large amount of valuable work for the profession in the State of West Virginia, and by its energy and courage has so reformed the practice of medicine in the State that quackery and quacks have been forced to seek patronage outside of its borders. A healthy and an honest public and professional sentiment has been developed in West Virginia in reference to scientific medicine. The people of the State enjoy the benefit of effective health laws, and are secure against the services of ignorant and dishonest practitioners of medicine.

The efficient work of this State Board of Health is an illustration of the benefit such an organization can confer upon the profession and public when its executive officer is a man of energy, courage and ability. Whilst not wishing to detract an iota from the value of the services of the other members of the West Virginia State Board of Health, we firmly believe that to its efficient and able Secretary, Dr. Jas. E. Reeves, of Wheeling, is due a meed of praise for the valuable work this Board has rendered to sanitary science and to legitimate medicine. These thoughts are suggested by the fact that Dr. Reeves has exhausted his physical strength in this work, and now, by reason of impaired health, has been forced to resign his position as a member of the Board of Health. The loss of the services of this public officer is deeply to be regretted by the profession everywhere, for Dr. Reeves labors were not local, but have had a wide-felt influence throughout this country. We wish for Dr. Reeves in his retirement an early restoration to health, and the honor and satisfaction he must feel for having so well and faithfully served his people and his profession.

Dr. Koch in his Laboratory.—Dr. K. is described as giving his personal attento his students, who are nearly all his own countrymen. The class is small, and each one is expected to devote his entire time to the work. Teacher and student live together in the most intimate manner, and the former is said to be always kind and attentive. Not to quote in detail the methods of research in the laboratory it may be enough to add that they are such as require a considerable knowledge of bacteriology, and hence the course is not one which is adapted for a novice.—*Cor. Brit. Med. Jour.*

Miscellany.

Misuse of Official Position.—We have before us the engraved copy of a letter from the Commissioner of Health of Baltimore, certifying to the merits of a secret cough nostrum. When a physician lends his name to such purposes, he not only does public injury but he destroys his professional standing. We can but hope that Dr. Steuart has been himself imposed upon.—*N. Y. Med. Record*, Feb. 14.

[We regret to say that Dr. S. has not been able to furnish any valid excuse for his act, but assumes the full responsibility for it in a card in the daily papers. We are informed that he has since resigned from the Academy of Medicine, Clinical Society and Medical Club, and that his *expulsion* was voted at the last meeting of the Medical Association. He is the last man from whom the profession would have expected such a thing.—*Eds.*]

Etiology and Prophylaxis of Puerperal Eclampsia.—*Dr. H. D. Fry*, of Washington, (*Am. Journ. of Obstetrics*, Jan.) concludes an article on the "Etiology and Prophylaxis of Puerperal Eclampsia" with the following recapitulation: 1. Puerperal albuminuria is the symptom of a pathological change or of pathological changes indicative of a predisposition to eclampsia. 2. The prophylactic treatment of eclampsia, therefore, includes measures adapted to prevent the occurrence of albuminuria, viz: improving the blood by tonics, iron and diet, relieving renal congestion by attention to the functions of the skin and prohibiting tight clothing. 3. The urine of all pregnant women should be examined for albuminuria after the fifth month and earlier if any suspicions are entertained of renal complication. 4. With the recognition of the disease treatment should be directed to its relief—general, dietetic, medicinal and obstetrical. To the last are referred the grave cases which demand, according to the urgency of their symptoms, prompt operative interferance.

Symptomatic Treatment of Typhoid Fever.—*Ebstein* (*Am. Pract.*) gives his experience at the clinic in Holstein for seven-and-a-half years. Number of cases 235; mortality 5.5 p. c., which might be reduced to 2.5 p. c. by excluding inevitably fatal cases. The so-called "abortion treatment" with colomel is useful, and to be recommended. In the absence of cause, treatment can only be symptomatic, *i. e.*, measures based on a consideration of the morbid phenomena and individual conditions; above all, attention to diet and nutrition. The control of high temperature, even long continued, is only demanded when it is associated with some cardiac or nerve symptoms, or when the temperature attains such a height as to threaten life. These principles are far more satisfactory than exclusive adoption of "bath treatment," or other methods of strict antipyresis. He regards baths as of value for their stimulant action, and would employ them where other methods seem insufficient.

Disinfecting the Sputa of Phthisis.—Dr. J. Sormani, Professor of Hygiene at the University of Pavia, gave some interesting details at the Hygienic Congress at the Hague, concerning experiments made this year on one hundred and fifty guinea pigs with the sputa from phthisis. The object in each case was to ascertain what chemical or other methods would neutralize the action of the bacillus which it was previously ascertained, existed in large numbers in the sputa. The results of these experiments were summarized in the following manner:

1. The bacillus of tuberculosis were generally very difficult to destroy; dryness, exposure to oxygen, putrefaction, and most disinfectants failed to produce any effect.

2. A temperature of 100° C. only killed the bacilli after at least five minutes of ebullition.

3. The artificial digestion of the bacilli showed that they were the last of all living organisms to be destroyed by the digestive juices or chloridic acid. A very active digestion is necessary to kill this microbe. A healthy man may destroy the bacilli in his stomach, but an infant or an adult with his digestive faculties impaired would easily allow the germ to pass the stomach intact, and retain its virulence in the intestinal tube. This determined enteric ulcerations, etc.

4. The bacillus of tuberculosis can be preserved intact for a whole year when mixed with water. It is probable, though not proved, that it has retained its viru-

lence during that time. Thus drinking water may become the means of propagating tuberculosis. It is probable that contaminated linen retains its virulence for five or six months.

5. Alcohol does not destroy the germ, and hard drinkers often suffer from tuberculosis.

6. Cod-liver oil, ozone, oxygenated preparations and other similar remedies have no effect in killing the baccillus, nor are benzoate of sodium, salicylate of sodium, sulphate of zinc and carbolic acid, iodide of silver, bromide of camphor, etc., of much use. They injure, perhaps, but do not absolutely destroy the bacillus—at least, not in the doses that can be taken without danger.

7. A more decisive action may be attributed to creosote, eucalyptol, pure carbolic acid, the naphthols, and bichloride of mercury.

8. For disinfecting spittoons, carbolic acid solution at 5 per cent. is thought sufficient, and Dr. Sormani asserts that the breath never contains any bacillus. He also suggested that essences of turpentine or eucalyptol should be diffused in the houses as an agent for the destruction of this special germ.—*Lancet.*

Intestinal Obstruction.—*Mr. Paul*, of Liverpool, (*Lancet*, Dec. 20), states that during five years in which he had been pathologist at the Royal Infirmary twenty cases of intestinal obstruction had been admitted; ten of these died. Of the latter, in three there were slight bands in vigorous young subjects, in one the same in an old man, in one a twist in a woman of fifty-one, in two concretions in the appendix cæci; one depended upon acute pelvic inflammation after confinement, one upon adhesions of the small intestine to a cancer of the rectum, and one upon ræcal accumulation, ulceration and perforation in an old woman.

Mural Pregnancy.—*Dr. Wm. H. Byford* reports the following case in the *Chicago Med. Jour. and Ex.*, for January, 1884: Patient, æt. 28, married seven years, with one child, æt. 6. Supposed she became pregnant February, 1883. In April had hemorrhage lasting four weeks. October 14th, "about a gallon" of yellow fluid was discharged, followed by a putrescent sero-sanguineous discharge lasting three months. In January, 1884, a large brownish fœtid mass came away. Soon after menses reappeared, and continued till July. In May she was quite large, and had bearing down pains. Entered hospital October 6th. October 18th was tapped, and four quarts of thick fluid resembling that of an ovarian tumor, coagulating from nitric acid and boiling hot, without the Drysdale cell, were withdrawn. Laparotomy was done, fœtus, placenta and uterus removed. Patient died in twenty-four hours. The retrograde changes which had been going on greatly obscured the nature of the case and the diagnosis. The walls were thickened and indurated; the fluid in the sac was viscid and contained much albuminoid material, rendering it impossible to distinguish the shape or even presence of the fœtus. Dr. B. believed it to be an extra-uterine pregnancy, but could not demonstrate the fact without incision, and it was not until the whole was removed that the character of the pregnancy could be determined. Prior to the operation the patient was extremely reduced by her sufferings. In a similar case Dr. Byford would now elect the vaginal operation. An incision made through the posterior vaginal wall would completely uncover the presenting part, and enable one to apply the forceps, or attack it with the perforator and crotchet as in ordinary labor. After removal of the fœtus the placenta should be allowed to separate spontaneously. The opinion being expressed by some of the members that it was more likely an abdominal pregnancy, the ovum having become attached to the posterior wall of the uterus, Dr. B. said that he was very positive that it was mural. The muscular elements of the sac were directly continuous with the uterine muscle. He did not believe that such a muscular sac could develop adventitiously in the abdominal cavity. He had seen cases of abdominal pregnancy in which the sac contained no muscular fibres. The head presentation deep down in the pelvis, in the direction of resultant of the forces developed by uterine contractions, supported his view. The specimen was referred to a pathologist for examination.

Cure of Epilepsy by Trephining.—In January, 1884, *Dr. W. W. Cleaver*, of Lebanon, Kentucky, (*Amer. Practitioner*,

February, 1885), was consulted by a young man who was having 3 to 5 epileptic convulsions daily. He found a depression in the right parietal bone, the result of a kick from a horse. This, however, gave him but little trouble. Over the right orbital arch was another depression in the frontal bone, due to a kick of a horse sixteen years previously, made by a calk of a horse's shoe; the patient was confident this was the seat of his trouble. This last kick was followed with convulsions which continued for a time, and then ceased for ten years. Meantime he married and had six children. The convulsions increased in severity and frequency, and he was urgent for relief. Accordingly under ether a button of bone was removed at the site of the frontal depression. A very thin spicula of bone was found imbedded in the dura mater which it was impossible to remove by the gentle use of the forceps, and it had to be picked off piecemeal. Good drainage was established, the temperature went over 100° only once, and the pulse remained at about 80. The next day slight symptoms of fits were felt twice, but have not been repeated, and the patient is now well.

Sponge left in Abdomen after Ovariotomy.—*Dr. D. A. K. Steele*, (*Chicago Med. Jour. and Ex.*, January, 1885), reports a case of ovariotomy in which the patient did well for forty-eight hours after the operation, but symptoms of pyæmia then appeared aud she died on the fifth day. At the autopsy a small sponge with a string attached to it was found in Douglas's *cul-de-sac* firmly imbedded in lymph. No hemorrhage had occurred, but general peritonitis had set in and the cause of death was quite apparent. But for the presence of the foreign body the patient would doubtless have recovered, and it seemed almost impossible that it should have been overlooked when the final count was made. *Dr. Parkes* said he was present at the operation, and he remembered the precautions that had been taken to guard against such an accident.

Life-Saving from Drowning by Self-Inflation.—*Dr. Henry R. Silvester* (*Lancet*) makes the inglorious suggestion that he inflation of the cellular tissue of the upper part of the body can be accomplished by making an opening in the mucous membrane at the junction of the gum and cheek with a knife or sharp piece of wood, and then filling the mouth with air and blowing it forcibly through the opening into the fascia. Sufficient inflation can be obtained in three minutes to support the body in water.—*Phila. Med. Times.*

Dr. Austin Flint on Cavernous Respiration.—(*Am. Practitioner*). More than thirty years ago he pointed out the distinctive characters of cavernous respiration in a prize essay; he has reiterated them since that in all his writings upon physical exploration of diseases of the chest. The inspiratory sound is non-vesicular, non-tubular and low in pitch; the expiratory is nontubular and lower in pitch than the inspiratory. Nothing can be simpler than these characters of the sign, and there is no sign the distinctive characters of which are more reliable. A respiratory sound, with the characters just stated, is a cavernous respiration, and is never aught else than the sign of a cavity. Its distinctive characters may be demonstrated not only clinically but by artificial respiration in lungs with cavities removed from the body. He has also illustrated them outside of the body in his didactic lectures by a very simple mechanical contrivance, No physical sign rests on a firmer basis than this; yet after thirty years its distinctive characters are not fully recognized in this country, England or France. The Germans ignore a cavernous respiration altogether. Following Skoda, they consider that and bronchial respiration as identical, the latter to be regarded as representing when associated with certain other signs. Now with a knowledge of the characters of cavernous respiration it is impossible to confound it with the bronchial. The characters of the inspiratory and the expiratory sound in the two signs differ intirely in pitch and quality: in the bronchial the sounds are high and tubular, in the cavernous low and nontubular. Not unfrequently the two signs are to be found in close proximity to each other. This is when a cavity is surrounded by solidified lung.

It may be found that moving the pectoral extremity of the stethoscope an inch, or even less, the ausculator passes from the cavernous to the bronchial respiration. The time must come eventually when the distinctive characters of the cavernous respiration will be universally recognized.

Disinfection by the Fumes of Sulphide of Carbon.—The combustion of this fluid being accompanied by the formation of considerable quantities of sulphuous and carbonic acids, M. P. Vigier has recently recommended its use for the disinfection of rooms and hospitals. Two or three litres of sulphide of carbon were placed in an earthenware jug and ignited. The room is then closed as hermetically as possible, and soon becomes filled by the fumes, which in all probability possess powerful germicide properties. Exact experiments have, however, not yet been made.—*London Med. Rec.*

Bismuth Injections in Dysentery.—*Dr. F. E. Waxham* (*Archives of Pediatrics*, *Am. Practitioner*) says this disease may be modified and often quickly abridged by this means. From ten to twenty grs. are injected with mucilage and water after each evacuation, and if not sufficient alone to control the frequent stools, a little laudanum is added. A child suffering from a severe attack, with rectal prolapse at each passage, was almost immediately relieved, the passages being entirely changed within twenty-four hours; the tenesmus and frequent desire ceasing, and the prolapse not recurring after the second or third administration. This is only one of many cases where this remedy has been used with gratifying results. In very severe cases opium in some form, preferably tincture, may be added with benefit.

Management of Patients during Etherization.—*Dr. H. L. Burrell* (*Boston Med. and Surg. Jour.*, Jan. 29th) offers the following propositions, which he takes it all will accept:

1. Before etherizing, the surgeon should satisfy himself regarding the presence or absence of heart disease. 2. The safety of the patient and comfort of the etherizer largely depend on the use of pure anhydrous sulphuric ether. 3. The best medium for the administration is one in which the ether can be given in a condensed form or largely mixed with air. 4. As a rule the patient should have a clear brief description of the sensation he is about to experience. 5. A room free from bustle and confusion before and after an operative procedure is an essential for quiet etherization. 6. Ether should be administered on an empty stomach. 7. The knowledge of the effect of a glass of wine upon a patient is frequently an indication of the exciting or stupefying effect that ether may have. 8. No mechanical impediment should exist to respiration. 9. The pulse and respiration are the safeguards of etherization. 10. The less ether used in an operative precedure the better the recovery of the patient from the immediate effects of the operation. 11. A little ether in children goes a long way.

Comma Bacilli.—The authorities of Genoa having placed a well-equipped laboratory at the disposal of Prof. Antonio Ceci, he, with Prof. E. Klebs, instituted a series of researches on the etiology of Asiatic cholera. *La Revista Internazionale de Med. e Chirurgia* gives a preliminary report of the joint research. Its results, so far as concerns the comma bacillus, do not accord with those of Prof. Koch. The Genoa observers conclude that comma bacilli are not invariably present in the fæces of cholera patients, or in the intestinal contents of the cadavers of those who have rapidly succumbed to the disease. They also failed to discover the comma bacillus in the air expired by patients in the algide stage of cholera; the blood of these subjects presented under the microscope, no other morphological changes than increase in the number of white corpuscles, and deeper coloring of the red corpuscles due to cyanosis. The symptoms, death and organic changes of individuals stricken with rapid cholera are not explicable by the slight lesions found in the intestine. In perfectly fresh cases in which epithelium still existed *in situ*, no comma bacilli were found in the glands of Lieberkühn, although lymphatic cells abounded in the mucous membrane. So far as concerns their morphological characters the comma bacilli and spirilli of Asiatic cholera proved identical with the comma bacilli and spirilli obtained by Finkler & Prior of Bonn, from the culture of the fæces of cholera nostras patients. The same forms of spirilli were found by Klebs in the diarrhœa of an individual suffering with pneumonia.—*Lancet*, Dec. 20.

Dr. W. Cheatham on Jequirity.— *Dr. Cheatham*, of the University of Louisville, has used jequirity in seventy-five cases with almost uniform success, and has yet to see bad results. Has used it in almost all

stages of granular ophthalmia; in one acute case, after failure of usual remedies, it was promptly successful. Employs an impalpable powder, everting the upper lid, and with a little cotton on a holder brushing a little of the powder on the conjunctiva. The first time uses a very small portion cautiously; should this not excite excessive inflammation, nor correct the granulations in three or four weeks, applies a larger quantity. Believes the results are better the more rapid the inflammation; hence the powder is of more service than infusion. It can be kept for months (if not always) without loss of strength, whereas infusions have to be freshly made. Thinks the danger from jequirity over-estimated. The inflammation is so easily controlled by cold water that its dangers are reduced to minimum.—*Ther. Gazette*, January.

Medical Items.

The *London Lancet* says it has been determined to spend £120,000 in erecting new scientific buildings in connection with the University of Turin. Half that sum will be provided by the Provincial and Communal Councils of the city and the other half by the Government, with the sanction of the Italian Parliament.

The deaths from patent medicines are estimated by a writer in the *Brit. Med. Jour.* to be about one hundred and fifty thousand annually.—*Med Record.*

Professor L. McLane Tiffany performed the operation of nephro-lithotomy at the Hospital of the University of Maryland on Saturday last. The patient was a male, aged 26, and the stone, which weighed 556 grains, was removed from the pelvis of the right kidney. The patient is doing well.

Gov. Jackson has appointed Dr. L. D. Wilson Secretary of the State Board of Health of West Virginia to fill the vacancy occasioned by the resignation of Dr. James E. Reeves. Dr. Wilson is said to be a physician of skill and ability. If he makes as efficient and valuable an officer as his predecessor the profession of his State will have occasion to rejoice.

The Texas *Courier Record of Medicine* states that the Physician's Mutual Benevolent Society of Texas is steadily increasing in membership, and is supported by the best physicians of the State.

A Bill to Regulate the Practice of Medicine and a Bill to Create a State Board of Health in Texas, has finally been perfected by the Committee on Legislation, appointed by the Texas State Medical Association. *Courier Rec. of Med.*

It is definitely announced that the Montreal School of Medicine and Surgery is about to apply to the Legislature for a charter granting it University powers, and thus enabling it to grant degrees.—*Canada Med. and Surg. Journal.*

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from Feb. 17, 1885, to Feb. 24, 1885.

Bentley, Edwin, Major and Surgeon. Relieved from further duty at Fort Clark, Texas, and assigned to duty as Post Surgeon, Fort Brown, Texas. S. O. 17, Dpt. Texas, February 16, 1885.

Patyki, Julius H., Captain and Assistant Surgeon. Leave of absence further extended seven months on surgeon's certificate of disability. S. O. 40, A.G. O., February 17, 1885.

Taylor, M. E., Captain and Assistant Surgeon. Assigned to duty at Fort Stanton, N. M., as Post Surgeon. S. O. 17, Dpt. Mo., February 21, 1885.

Perley, H. O., Captain and Assistant Surgeon. Granted leave of absence for one month, to take effect about March 5, 1885. S. O. 16, Dpt. Dak., February 10, 1885.

Robinson, S. Q., Captain and Assistant Surgeon. Relieved from duty at Fort Spokane, W. T., and ordered for duty as Post Surgeon, Fort Klamath, Oregon. S. O. 23, Dpt. Col., February 9, 1885.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service for the week ending February 21, 1885.

Battle, K. P., Assistant Surgeon. To proceed to Pittsburgh, Pa., for temporary duty. Feb. 19, 1885.

RESIGNATION.

Heath, W. H., Passed Assistant Surgeon. Resignation accepted, as tendered, by the Secretary of the Treasury. Feb. 14, 1885.

PROMOTION.

Kalloch, P. C., Assistant Surgeon. Promoted and appointed Passed Assistant Surgeon by the Secretary of the Treasury, from March 1, 1885. Feb. 19, 1885.

Original Articles.

SPASMODIC TABES DORSALIS.*

BY JOHN M. KEATING, M.D.

An interesting article appears in the *Revue Mensuelle des Maladies de l'Enfance*, December, 1884, by Dr. d'Heilly, on "Spasmodic Tabes Dorsalis," relating three cases, from which we gather the following valuable points, by literal translation:—

About 1875, Prof. Charcot separated from the group of chronic myelitis an affection described as *spasmodic* tabes dorsalis, which was about the same time written upon by Erb, under the name of spastic paralysis. It is a chronic affection characterized by slow and gradual progression, without doubt, of spinal origin, with a paresis of the lower extremities, muscular contraction, and with spasmodic tremors, either occurring when the limbs are touched or movements attempted, or else spontaneously. There is also increased tendon reflex.

It is most frequent in adults, but Erb, Seeligmuller (*Progres Médical*, 1876), d'Espine and Picot, have recorded a number of cases in children. In these cases, motion alone is affected; sensibility remains throughout normal. The disease may begin early; at eight months in one case of three reported, at two and one-half years in another. Ordinarily it is first found out by the mother, who finds difficulty in flexing the knees, or in separating the legs. In well-marked cases, the legs are stiffened, as the child lies in bed, from time to time, especially the feet, which are also turned in (equino varus); there is contraction of the adductors and extensors of the thighs. At times, the rigidity becomes marked, often the knees are held in slight flexion, and it requires some force to move them. On exciting this the limbs are thrown into a tremor, which may be limited to the feet, or may extend to the muscles of the trunk —in fact, to the whole body. If the child be placed upon its feet, by grasping it by the body or arms, the thighs, which are flexed upon the pelvis more or less, will be adducted, the knees touching, the feet will assume a position of forced extension. In attempting to walk, the feet will drag along the ground, stumble over the least obstacle, and constantly interfere with one another. None of the children reported could walk absolutely alone; one could walk a few steps, when supported by an object upon which it rested the weight of the body by the arms; the gait was shuffling. The epileptiform tremor of the muscles is at first provoked by standing, and this greatly hinders the walking. In three cases reported, the upper extremities were not involved. This is not absolutely the rule in all cases, but when the arms are involved this follows the trouble in the lower limbs, usually at a long interval. In such cases, there is a paresis of the muscles, without involuntary flexion of the fingers at first, which is intermittent in character, and then permanent. The wrist becomes rigid in extension and pronation, so also the elbow, and the arm is hugged to the thorax.

With rigidity comes exaggerated tendon reflex, which, according to Charcot, precedes contraction, and which persists throughout its course, and succeeds it. It is usually very marked in the knees, less so in the feet, and in children is less so than in adults. The symptoms remain confined to the motor tract throughout the disease; the usual symptoms, due to disturbance of sensation, which accompany the different forms of myelitis are absent. There is no rachialgia, no feeling of constriction, no pain; neither are there sensations of cold, nor formications, nor fugitive pains, which, if they existed, would soon be made known by children.

Cutaneous and deep sensibility are normal; there is neither hyperæsthesia nor anæsthesia. In one of the cases observed, there was some well-marked anæsthesia of the lower extremities, but the case was a doubtful one. Sometimes, according to Westphal and Berger, interstitial myelitis may extend itself, involving the posterior tract, and then the symptoms of ataxia complicate the spasmodic contraction. The functions of the sphincters are normal; there is neither retention of urine nor incontinence, which is remarkable for children with disease of the cord.

The muscles of the thigh are not atrophied, and electro-contractility is normal. In one of the cases reported, nutrition was excellent; in the other two, it was somewhat below par, but this was accounted for

*I would suggest a better name in "Symptomatic Spastic Contracture of Infancy." Read before the Philadelphia County Medical Society, Jan. 28, 1885.

by the prolonged, enforced rest in bed. The duration of the disease is not limited; complete cure is rare. The symptoms persist indefinitely, despite treatment, without much improvement; if they do become aggravated, the disease is even of itself directly fatal. In children, the zymotic disease, or most frequently tubercular disease, makes a fatal termination. It is to be regarded as an infirmity rather than a disease, as it will not prevent of itself the patient reaching adult life. We have only written of the affection in its bearing upon children. In adults it is most common, at the age between thirty and fifty, and slightly more frequent in males than females. The cause is unknown; possibly prolonged exposure to damp cold is the most frequent. In children, possibly blows, a fall, or exposure. There is a congenital form, which possibly results from an arrest of, or from irregular, development in the motor tract, or is traumatic from instrumental or difficult labor. Little records a case such as this, and attributes it to spinal congestion, due to asphyxia. Possibly inheritance has its influence. In the case narrated below, the other twin was born with arrested cranial development, and lived but a few moments.

The following case serves as an example:—

Louis, aged five years, entered the hospital (Trousseau) August 30, 1883. The child is a twin, its brother survived but a few moments. The father and mother are in good health, they are not affected with syphilis nor alcholism. The mother has never miscarried. The child has never walked alone, but since three years old he could stand alone with the aid of fixed support and could take a few steps in that way. He began to talk at the age of eighteen months. The disease dates from his eighth month, at which time the mother noticed that she had difficulty in separating the legs of the child; they were straightened and stiffened at times, then became relaxed, and the conditions would again recur, either spontaneously or upon the slightest contact. The arms were in every way normal. About a month after tremor was noticed when the child was lifted by the arms and held upright on the table. In the following month the contractions increased, and if forcibly overcome would return by themselves at once. Cold douches and faradization brought about some improvement, the permanent crossing of the limbs disappeared and the intervals existing between the spasmodic contraction of the muscles lengthened.

The condition of the patient at present is as follows: The muscles of the lower extremities are in a state of contraction, the feet extended in equino varus and cannot be overcome without considerable force. There is no notable muscular atrophy. When the child is held upright the contraction increases, the inferior extremities are adducted, the feet in equino varus resting in their metatarsal phalanges. The legs cross and the foot in advance tends to place itself directly in front of the one supporting the body. The little patient can only take a few steps by supporting himself on his arms. At times the contraction subsides entirely and the limbs become flaccid, but if the limbs are touched, however lightly, or he makes the attempt at movement, the contraction returns. Patella and plantar reflexes are exaggerated. Faradic contractility is normal. When supported erect the two limbs take upon themselves epileptiform movements which can be equally well provoked by seizing roughly the foot in advance. This tremor is more pronounced in the right limb. There has been no pain either spontaneous or upon pressure. Sensation is normal. The intelligence is somewhat undeveloped. The expression is heavy. Speech normal. The cranium shows faulty development, it is not symmetrical; posteriorly it is flattened. The frontal fossæ, especially the left one, very prominent. The right occipito-parietal region comes out in bold relief, and the left is correspondingly depressed.

The following typical case, reported by Dr. C. K. Mills, in *New York Med. Record*, Sept. 6, 1879, presented in detail the marked features of the disease, and as I now have the patient under my care, and have been able to study his present condition in contrast to what it was in 1879, I can dwell more at length upon the prognosis.

B. D., æt. 4. Nothing known of the previous history. He has a fair-sized head, but it is flattened a little more than usual from the vertex forward. The fontanelles are closed, but the lines of the sutures are projecting and rough. Both pupils are dilated, and according to the nurse they are

always in that state. He has left internal strabismus. He has no facial paralysis, he can protrude the tongue without difficulty and he talks pretty well. He seems to have fair intelligence, but he cries upon the least provocation. His back seems weak and tends to project backwards as he sits in the chair. He has no spinal curvature. He has good use of his arms, but they show a tendency to flex at the elbows. They frequently get into a semi-flexed position when he is quiet, and sometimes resist extension slightly, but they are not rigid, and he can straighten them himself without special effort- He is unable to stand alone, and if attempts to force him are made he becomes much alarmed. If not held, he falls at once to the floor. Supported by the hand or from behind, he stands in a peculiar position. The legs from the knees upward are slightly drawn together, below the knees they are a little apart. His heels are kept slightly elevated. The thighs are bent on the pelvis at an angle of about 120°, and the legs have about the same inclination as the thighs. The feet turn slightly inward. The flexors and adductors of the thighs and the muscles of the calves feel hard and are in a condition of tonic spasm. He walks in a curious fashion, keeping hold of the hand of the nurse. His legs remain semi-flexed at the knees. He steps on the front part of his feet and toes, the heels never touching the floor. The thigh and leg muscles are fully developed, particularly the flexor group. Electro-contractility is generally well retained. Sensibility is good. The limbs are not cold or changed in color. The joints are free from adhesions. The prepuce is not adherent and can easily be retracted. When sitting or lying down, his legs can be straightened by the exercise of some force, but they immediately tend to return to their state of abnormal flexion and adduction. Slightly tapping each patella tendon, the corresponding foot and leg are projected quickly and somewhat forcibly forward. I can produce the same phenomenon by tapping upon the lower part of the tibia. Abruptly forcing the foot into flexion and smartly striking the tendo achillis no tremor or oscillation is set up, but the spasm of the flexors and adductors is increased.

Dr. Mills concludes that the disease is one of the motor disorders of the cord of the lateral or antero-lateral columns, but should not be confounded with primary lateral sclerosis, also congenital.

Sam'l Gee (Bilroth Hospital Reports, vol. 13, 1877), writes of spastic paraplegia, and considers the disease as congenital or beginning in infancy. Dr. S. W. Mitchell is quoted by Dr. Mills as having spoken of cases of children with rigidity of the legs from defective cerebral development and also of cases of spasms of the adductors of the thighs, in which he has had circumcision performed without benefit. Dr. Mills, in this lecture, quotes a case which he saw with Dr. Roland G. Curtin, of this city, where all the symptoms above recorded followed an attack of rheumatism complicated with endocarditis in a girl of 13. She had in addition severe pains or aching in the joints or limbs. Under nitrate of silver she rapidly improved, and in two weeks was well.

In the continuation of his interesting article, Dr. d'Heilly (*Revue des Maladies de l'Enfance*,. January, 1885) discusses the question as to the cause and seat of this interesting symptom, quoting the researches of Richter and Berger in Germany as showing its dependence in many cases upon a primary sclerosis of the lateral columns. But, again, distinct cerebral symptoms, such as convulsions in infancy have initiated the attack and the spastic paraplegia following, being in such cases a secondary phenomenon—and in connection with this, quotes Ross (*Spas. paral. of infancy*, *Brain*, October, 1882) as asserting, that although there may be a localized spinal lesion primary, the most usual condition is one of arrest of cerebral development, associated with a bilateral hemiplegia from congenital absence of certain centres but should this latter explanation be correct, less marked cerebral symptoms should exist, than are presented by the cases—almost all the affections of the cord resulting from pressure, or from sclerosis, present more or less certain features which show an involvement of the lateral columns, in most of them there is pain or anæsthesia, vesical paralysis or paresis, muscular atrophy or incoordination of movement and the tendency of most of them is to extension.

The ataxia of Friedrich presents many symptoms in accord with this disease. Sensation is normal. The bladder is unaffected, and there is no muscular atrophy. There is muscular inco-ordination and gradual

involvement of the arms, and finally speech is affected. Frequent errors are made in diagnosis in such cases. Even Charcot is reported by d'Heilly as recording a case of supposed spastic paralysis in which the existence of cerebro-spinal sclerosis "en plaques" was found post-mortem.

As d'Heilly distinctly emphasizes the fact that "spasmodic tabes dorsalis" never presents any cerebral symptoms, those cases which are recognized as distinctly hemiplegic in character should be eliminated (see excellent paper by Dr. Sarah J. McNutt, *Archives of Pediatrics*, January, 1885,) and also double infantile spastic hemiplegia (same author, *Am. Jour. Med. Science*, January, 1885). In the latter affection, which more than any other may possibly be confounded with the one in question, Dr. McNutt's exceedingly valuable paper gives us as symptoms "more or less complete hemiplegic motor inability with contraction and defective development of both bones and muscles," with or without aphasia, monosyllabic utterances, dysphagia, dyspnœa and idiocy, the latter being especially characteristic of the double affection."

We have endeavored to epitomize this interesting communication, because we believe these cases to be overlooked in this country or misunderstood. The diagnosis is readily made in marked cases, especially in adults; doubtless some will read this article and remember cases of their own which had puzzled them. Certainly in the cases referred to by Dr. d'Heilly, there was a lesion of a more or less peristent character, but are there not functional derangements, prototypes of the more serious disease, whether disturbances in nutrition or in circulation, which can be influenced by treatment? Can we not have one form depending upon imperfect development of cerebral centres, and another, possibly a difference in degree only, affecting in the same way those of the cord? Cases of functional paraparesis in infancy, with spasmodic adduction, are certainly noted by all who see much of children's practice, and in such cases the muscular wasting, when it does occur, is secondary, owing to want of use.* In our own experience these congenital cases seem to be due to imperfect development, as the intellect shares this condition, though to such a slight extent as only to be noticeable by comparison; the child is said to be backward.

Functional contractions are not infrequent after acute diseases in infancy. A child of my own at the age of twenty months had spasmodic closure of the fingers and great rigidity of the wrists, immediately ly following a mild attack of Rötheln, which lasted several days (3 or 4). There was no pain apparently, and none of the other muscles were affected. When playing, she lifted her toys with the back of her wrists. Nutrition was perfect, the functions normal. In this case relaxation would come on at times, but the slightest touch or effort on her own part would bring about violent contractions. There was relaxation during sleep. I noted this same condition following measles, in an infant, which involved the muscles of both arms and legs, the extensors of the legs and the flexors of the arms, with contraction of the toes and fingers. There was pneumonia in this case, and the temperature ran high. The little patient gradually improved, in fact in both these cases the improvement was very gradual. Large doses of bromide of potassium, hot baths and friction, with tonics, were used in the first case, and in the latter quinine and poultices in addition. Possibly these cases may be called hysterical. The lesion is evidently an irritative one, but exactly why it should be limited to certain cord centres and be painless, is an interesting problem.

But in such cases as reported by Dr. d'Heilly, when changes have probably taken place of a definite character, and especially if they occur in children but a few months old, our only chance for treatment points to alteratives, tonics and encouraging nutrition.

Like all other symptoms, contraction may represent in infancy and childhood as well as in adults, simple irritation, hysterical possibly, and every grade to advanced disease. I think chorea may be classed in this category also.

As for the treatment of well-marked cases of spasmodic contraction, there seems but little hope of doing good. The disease, whatever its lesion may be, is limited, is never fatal, and after reaching a stage about as advanced as the boy B. D., quoted from Dr. Mills' report, somewhat improves. This

*This I believe should not be confounded with the so-called Idiopathic Contracture of Infancy which is the result of irritation and is painful and acute in character.

boy can now take a few steps by himself before the muscular spasm upsets him; he is in excellent health, well nourished, muscles firm, and never complains. But in this case the lesion certainly seems to be a bilateral central one. If we are able to recognize the features of the disease of the spinal types in its incipiency, I believe much could be accomplished, and it is for that I bring this matter before you this evening.

All causes of irritation should be removed. If they are males, possibly prepucial adhesions are present, they should be broken up or circumcision performed. In my opinion the latter is a most important operation, not so much from the relief to the phymosis, which could be in many cases, equally well accomplished by stretching (Willard), but owing to the direct results upon the nutrition of the spinal centres, which section of the peripheral terminations of the nerves in the prepuce may bring about, acting as does the actual cautery or blisters in other neuroses. In females I would give warm baths, alternating with cold sponging, especially to the spine, and full doses of bromide of potassium. In incipient cases, the bromides are of great importance, with stimulating frictions to the spine, using either mustard poultices, or liniments of oil of amber or croton oil, or possibly dry-cupping. Fresh air and proper diet are, of course, understood; in the latter, milk should always form the principal part, and eggs also, in preference to animal broths. As regards medication, I would insist upon an emulsion of cod liver oil, either with liq. acid. phos. comp. (Pepper), or lactophosphate of lime. Arsenic is certainly of great value in these cases. As to quinia and strychnia, I feel doubtful as to their use, even in very small so-called tonic doses; for although the condition is possibly an evidence of anæmia, as are chorea, and some mild forms of epilepsy, I would prefer to rely on food, iron, arsenic and fresh air.

In more pronounced cases, when we have decided evidences of "spasmodic tabes dorsalis," and treatment has been of little avail, we might use the bichloride of mercury, in small and frequent doses—$\frac{1}{150}$ of a grain, three times daily; or if we suspect sclerosis, the chloride of gold and sodium. But I think that the best results are obtained with the nitrate of silver; in it I would place most reliance. Erb is reported as having cured a case with the continued current. Charcot failed with electricity, hydropathy and cauterization.

A REPORT OF TWO CASES OF OVARIOTOMY.

BY L. E. NEALE, M. D., OF BALTIMORE.

CASE I.—*Multilocular Cyst. Operation Oct.* 3, 1883. *Normal Menstruation, Oct.* 5, 1883. *Delivered of Living Child, Aug.* 29, 1884.—Mrs. F., Italian, æt. 23 years; married; two children; no miscarriages; a woman of average size and physical development, accustomed to the hardships and deprivations of poverty.

Her first menstruation appeared at the age of fourteen years, and recurred every month until her last pregnancy, which terminated at full term in March, 1883, since which time she did not menstruate again until the second day after the operation.

About the end of May, 1883, she first noticed a tumor in the right iliac region, which, by October of the same year, developed to the size of an eight months' pregnant uterus.

During the first two weeks of September, the patient narrowly escaped death by acute peritonitis, which reduced her to quite an enfeebled condition.

As soon as she sufficiently recovered from this attack she was given into my charge by the late lamented Dr. D. I. McKew. She was immediately placed in St. Vincent's Hospital to await operation.

I will say, in passing, that the tumor presented no difficulty in diagnosis whatever, and was readily recognized to be a multilocular cyst of the right ovary, which fortunately had never been tapped.

After the usual preparations, the operation was performed October 3rd, at 1.20 P. M., in the presence of ten doctors, in a well-ventilated second story corner room, which had been aired and cleaned on the preceding day. No other antiseptic precautions were taken, either before, during, or after the operation, except that all water used had been previously boiled and was carbolized only sufficiently to give everything a general antiseptic odor.

Morphia hypodermically immediately preceded the inhalation of ether.

The incision in the linea alba, midway

between the umbilicus and symphysis pubis was about two and a half inches long.

Bleeding was checked by the compression forceps of Sir Spencer Wells, when the peritoneal cavity was carefully opened, and no ascites being present the tense cyst wall came into view.

About two gallons of a dark coffee-colored fluid, containing lumps of broken-down tissue or debris, was drawn off through a trocar. Adhesions were found: (1) to the left lateral abdominal wall, (2) to the intestines, both slight, and (3) to the omentum, strong.

This knuckle of adherent omentum was ligated and cut off.

A very short pedicle coming off from the right broad ligament, close to the uterus, was tied with a bisecting silk ligature, the sac removed, and the stump dropped into the peritoneal cavity.

A careful peritoneal toilette was made, the abdominal incision closed by six deep (including peritoneum) and one superficial silk sutures, a simple dressing of oil-silk cloth covered by thick layers of salicylated absorbent cotton held fast by adhesive straps, and a flannel binder over all, was applied, ext. opii aq. grs. iss, in rectal suppository administered, hot bottles placed against the trunk and lower extremities, and the patient put to bed. The duration of the operation was one hour.

The patient rallied well, with only slight nausea, which soon yielded to a little brandy and warm water, five to ten drops to the teaspoonful. Slight abdominal pain was relieved by an opium suppository, the urine was at first drawn by a catheter and everything continued most favorably.

Her first food, taken Oct. 4th, was two teaspoonfuls of beef peptonoids in ℥iv of warm water injected slowly into the rectum, to be repeated every four hours if well borne.

Oct. 5th.—Urinated voluntarily, and at 12 M. normal menstruation began.

Oct. 6th.—She first took food by the mouth; her menstrual flow gradually increased, and her bladder, bowels, pulse, temperature, etc., were all perfectly normal.

Oct. 11th, A. M.—All the sutures were removed, the union found to be perfect and the patient's general condition most favorable; menstruation ceased; a well-fitting silk elastic abdominal bandage was applied and maintained.

Oct. 13th.—She left the hospital and returned home.

Aug. 6th, 1884.—I saw her again and found her to be nearly at full term with child, of which I delivered her myself Aug. 29th, 10 A. M., after a very short, easy and perfectly natural labor. The child, a female, was well developed, of average size, and is now thriving; the mother was up and engaged in household duties on the fourth puerperal day and is at the date of this writing again (Feb., 1885) pregnant.

Case II.—*Malignant Pelvic Tumor; Round Cell Sarcoma, Resembling and Diagnosed as a Simple Ovarian Cyst. Removal by Laparotomy. Death on the Forty-second Day.*—Mrs. H., American, æt. 32 years; married; one child; menstrual function normal; health generally fair until the latter part of 1883; no family history of malignant or tubercular disease.

About nine months prior to my first visit the patient began to complain of more or less discomfort about the abdomen, gradually developing into sensations of weight, pressure and pain, accompanied by diminution and final suppression of menstruation.

All of these symptoms had become more pronounced during the latter five, but especially the last *three* months, for which time only had she noticed an abdominal enlargement growing in the right iliac region. The abdominal enlargement had somewhat rapidly increased during the last three weeks or one month, confining the patient to the house, where she spent the greater part of her time, propped up in a chair or bed, suffering considerably with dyspnœa.

I saw Mrs. H. for the first time during the latter part of September, 1884, in consultation with her regular attendant, Dr. Patterson, of this city, and Prof. G. W. Miltenberger. She was of a rather small stature, frail, somewhat emaciated and anæmic, and bore the anxious care-worn expression of dyspnœa. The abdomen was distended to about the size of an ordinary full-term pregnancy and gave all the physical evidences of ascites, which, as I have said, although probably existing for several months, had especially accumulated during the last one month of her sickness, notwithstanding the use of hydragogue cathartics and other treatment by her regular attendant. External palpation, vagi-

nal touch, and combined manipulation, all revealed the presence of a movable tumor about the size of an infant's head, apparently developing from the right lateral ligament, occupying a considerable part of the pelvic excavation and rising a little above the pelvic brim.

This tumor (for only one could be detected) felt like a distended cyst and *seemed* to impart an indistinct or uncertain sensation of fluctuation. All three physicians then in attendance concurred in this opinion. The uterus, not enlarged, was pressed in the hollow of the sacrum. In the absence of the manifestations of disease in any other organ, and in the presence of this history, with these signs and symptoms, we made the diagnosis of ovarian cyst, complicated by ascites, and advised early operation.

I again examined the case with Prof. Miltenberger and found nothing to cause me to alter our diagnosis, but still desiring to be doubly sure, prior to performing ovariotomy, I held consultation with Prof. Wm. T. Howard, of this city, who coincided in our opinion as to the diagnosis and treatment.

After the usual preparatory treatment, the operation was performed in a well-ventilated, recently-cleaned and aired room, of sunshiny southern exposure, in the patient's own house, Wednesday, Sept. 24th, 1884, 10.30 A. M., in the presence of five doctors and under no more thorough antiseptic precautions than those used in Case 1. Morphia hypodermically preceded ether, the anæsthetic employed.

A small incision in the linea alba soon opened the peritoneal cavity, whence several gallons of a straw-colored, clear ascitic fluid escaped.

The smooth, glistening wall of the supposed cyst, which presented a rather dark or venous hue, appeared above the pelvic brim, and as no immediate adhesions were felt, Emmet's small curved tocar was plunged in.

Much to my surprise only a few drops of thick, dark venous blood issued from the trocar. The instrument was removed, and from its track quite an amount of blood welled up and escaped into the peritoneal cavity. Upon introducing my finger into the hole made by the trocar, I found the tumor to be a sarcomatous mass of about the consistency of fresh brain, that readily broke down under the pressure of the finger and bled most alarmingly. It was about the size of a man's two fists or a small fœtal head, and cropped directly out, without any pedicle, from the right lateral ligament and the soft parts covering the posterior surface of the right anterior superior pelvic wall, resting in and upon the pelvic brim. While the woman was turned over on her side and the peritoneum kept as clean as circumstances would permit, with Prof. Howard's valuable assistance, (for which allow me here to express my sincerest gratitude) we finally succeeded in passing a carbolized stout silk ligature around the base of the growth, over and including tissue as firm and normal as we could possibly encompass, and after strongly tying the ligature, I broke the tumor away from its attachments leaving about one-half inch of jagged stump outside of the ligature. As the pulse now began to flag and respiration grew shallow, brandy was freely administered hypodermically.

Upon the removal of this mass another tumor was found partly filling up the pelvic cavity, coming off from the left lateral ligament and likewise apparently presenting all the characters of a cyst; unfortunately, however, whilst an assistant and consultant was examining it, his finger perforated its friable substance which proved to be of exactly the same nature as the first tumor, and possibly somewhat softer.

The peritoneal cavity could no longer be kept clean, for instruments, sponges, hands of operator and assistants, were all besmeared with this gelatinous brain-like substance of the medullary sarcoma. The patient was so rapidly weakening (pulse quick and feeble, respiration shallow, skin cold and clammy) that fears were expressed of her dying on the table; but brandy was liberally administered (some thirty odd hypodermics in all being given), and hot bottles applied, which seemed to sustain the flickering flame of life until the completion of the operation.

With considerable difficulty we finally succeeded in passing a silk ligature around the base of the tumor including tissue, as normal as we could find, and after firmly tying, removed the mass. No more tumors being found, and the uterus and remaining pelvic organs (both ovaries having been destroyed by the malignant growth) being apparently healthy, after a very rapid and possibly incomplete peritoneal toilette, the abdominal incision (which had been en-

larged during the operation so as to extend from the umbilicus to within two inches of the symphysis pubis) was closed with deep carbolized silk sutures close around a glass drainage tube which dipped down behind the uterus into the pouch of Douglas and opened externally into a mass of antiseptic absorbent cotton. A simple dressing, as in *Case I*, was applied, and the patient, by this time, almost lifeless, was put to bed with hot bottles, etc. The operation was somewhat over one hour and a-half in duration. The colorless, almost cadaveric-looking patient awoke from the anæsthesia with a sub-normal temperature and a very feeble pulse of one hundred and forty. Nothing whatever was given *per os*. During the evening nausea and slight vomiting, with no retching, occurred; indeed, almost from the very beginning this was rather a simple regurgitation. About a tablespoonful of almost clear, or slightly turbid fluid, would well up in the mouth, whence it was either spat out, or when the woman was too weak, merely received on cloths placed under the chin. At first this recurred every ten or fifteen minutes, for half a dozen times, until the intermissions became longer or the regurgitation ceased entirely for several hours, during which time the patient enjoyed sleep. Thus passed the first night with nothing of further interest save the occasional hypodermic administration of morphia. On the following day the urine was voided voluntarily, the pulse became slightly stronger and a little less frequent, while the temperature remained a shade above normal. The tube discharged bloody serum freely; the abdomen was not painful or swollen. Towards nightfall the regurgitation returned with more severity, and gradually became darker in color, until it assumed a coffee-ground appearance, and was of such an acrid, irritating character as to excoriate the skin. This discharge would, at times, without the slightest effort on the part of the patient, spurt from the half-opened mouth like a jet from a syringe. Brandy and warm water were administered, but rejected. As the night wore on this grew less and almost entirely ceased towards the early morning hours, or before the close of the second day after the operation.

Tympanitis abdominalis now began to develop and gradually increase, the sutures however holding firm; there was no real pain over the abdomen, the temperature did not rise above 101°, the pulse ranged from 110–120, the patient although extremely weak, was comparatively comfortable, and gave no positive evidences of peritonitis.

During the third day the tube discharged freely bloody serum, and, at times, almost pure blood; indeed, quite enough to term a secondary hemorrhage.

It is worthy of mention that from the time of its insertion to that of its extraction on the fifth day, fluids were sucked out of this tube and warm carbolized water injected into the peritoneal cavity through it, by means of a long curved nozzle hard-rubber vaginal syringe, about every three or four hours: a large antiseptic sponge being then held over its external orifice by dressings which were saturated with iodoform.

No food had as yet been taken, the regurgitation had entirely ceased, and Mrs. H. seemed to gain strength.

On the fourth day the abdomen was as tense and resonant as a drum-head; flatus began to escape from the anus, and it passed off in volumes, affording most marked relief, after the use of the following:

℞ Quin. sulph., grs. viii.
Acid. sulph. arom.
Tinct. nucis vom., *āā*, gtts. xv.
Aq. tepid, ℥ i=m.
S. Inject into the bowel.—(W. T. H).

Milk and brandy were cautiously given per os, the urine was voided voluntarily, the bowels moved and a general improvement was noticeable. On the fifth day after the operation, all discharge having ceased, the tube was removed and the granulating wound closed by adhesive straps. This orifice rapidly diminished in size to a filiform sinus, but on the night of Sept. 30th, *i. e.*, during the sixth day, it began to discharge a few teaspoonfuls of clear serous fluid, which, within the following twenty-four hours, contained little flakes of sarcomatous tissue mixed with laudable pus.

Oct. 1st, a small resisting mass was felt by palpation in the left iliac region and another still smaller (about the size of a chicken egg) just below the inferior border of the ribs on the left side; neither mass was at all painful to pressure, or seemed to have *any connection* with the pin hole orifice in the abdominal wall.

Oct. 2d, all the sutures were removed and the wound was found to have united beau-

tifully, with the exception of the little orifice indicating the track of the tube.

The patient was up on the same day, remaining for an hour or so sitting in a comfortable chair in the sunlight, and also at times made feeble attempts to walk. At this time the morning temperature was normal, pulse 110; the evening temperature rising to 100⅘ and the pulse remaining the same. Bladder and bowels were both functioning normally and her appetite and digestion were quite satisfactory.

She took no other drugs except three grains of quinine and ten drops of the tincture of the chloride of iron, each separately three times a day.

Oct. 7th, the stools became somewhat diarrhœal in character and a tablespoonful of the following mixture was administered every four hours:

℞ Bismuth et ammoniæ cit. ʒ ss.
Spts. ammoniæ arom. ʒ j.
Tinct. opii deod. gtts. xl.
Syrp. aurantii cort. ʒ ij.
Aquæ. q. s. ad., ℥ iv.
M.

During my evening visit of the same day the patient informed me that upon the removal of the dressings about a tea-cupful (?) of foul-smelling pus containing flocculi of fleshy matter (which I found to be sarcomatous) had escaped from the sinus. Temperature 100⅗, pulse 110; she felt comfortable, slept well, and on the following morning, Oct. 8th, walked about the room unaided. Both of the previously mentioned resisting masses on the left side, had by this time *gradually* but markedly diminished, and coughing, straining or strong pressure over the abdomen failed to force any pus out of the sinus, which however continued to discharge about two teaspoonfuls daily.

Oct. 9th, diarrhœa, hectic sweats and a low insidious general pyæmic condition accompanied by a very slight rise in pulse and temperature.

Oct. 10th, a vaginal examination revealed a resisting mass on the left side of the posterior pouch of Douglas, about in the same situation occupied by the internal extremity of the glass drainage-tube, or the stump of the second tumor removed. The two resisting masses felt *through* the abdominal wall, were now scarcely perceptible, and yet I was unable to demonstrate any connection they might have with the discharging sinus.

Oct. 12th, bubbles of air, having no foul or fæcal odor, escaped from the sinus.

Oct. 13th, the family having to change their residence, the patient was carried down stairs and removed in a hack a distance of several squares to another house. She still sat up and walked about.

At this time pyæmic arthritis developed and separately attacked in the following order: knee, wrist, metacarpal and sterno-clavicular articulations.

These joints would become red, swollen, hot, fixed and exquisitely sensitive, but distinct fluctuation was at no time perceived.

Oct. 20th, small specks of fæcal matter began to appear in the discharge from the sinus, which in a few days markedly increased in quantity, thus demonstrating the existence of an intestinal fistula.

Opium was required for sleep, and during sleep, no matter how short, the most profuse perspirations occurred, notwithstanding the use of oxide of zinc, aromatic sulphuric acid, sulphate of atropia, sage tea, etc., and increased doses of the tincture of iron.

In this wretched and pitiable condition, did my patient linger on, being gradually exhausted by the severe pyæmic sweats, the occasional appearance of diarrhœa, at times streaked with blood, the constant discharge from the fistula, the steadily progressing pyæmia, although both appetite and digestion remained fairly normal and no peritonitis developed, the temperature being either normal or sub normal, the feeble pulse about 140, until she was relieved by death on the morning of Nov. 5th, 1884, forty-two days after the operation.

Specimens of the tumor were examined by Dr. Councilman, of the Johns Hopkins University, and pronounced to be a small round cell sarcoma.

The following letter, mailed to Mrs. H's father, contains an account of a very hurriedly (from necessity) and imperfectly performed post-mortem.

Baltimore, Nov. 15th, 1884.

Dear Doctor: — In accordance with your permission and desire, I performed the autopsy upon Mrs. H., Nov. 5th ult. P. M., of which the following is a brief account:

Nothing was opened but the abdominal cavity, which revealed:

1). Incision perfectly united throughout, save the filiform sinus at the lower extremity perforating the entire thickness of the abdominal wall and communicating with,

2) A cavity large enough to admit two fingers their entire length.

This cavity was bounded above by superimposed coils of intestines adherent to one another by lymph, and below by the anterior pelvic wall and the posterior walls of both bladder and uterus, much thickened by interstitially developing medullary sarcoma.

3). The lower extremity of this track communicated with the bowel by a small connecting opening in the anterior rectal wall, probably caused by gradual pressure, infiltration and growth of—

4). The redeveloping tumor from the old stump.

5). The anterior wall of the stomach was over one-half of an inch thick, being thoroughly saturated with the small round cell sarcoma.

I have no doubt that this metastasis had occurred in various other abdominal organs not examined, and had thereby literally eaten away or consumed the life of my poor patient.

There was no sign of peritonitis or ascites or other pathological evidences of any description whatsoever.

In the light of these facts, I do not think it can be doubted that the patient died from the remote and immediate effects of the malignant disease, and not from the operation.

CRIME AND ITS CAUSE.

BY A. VANHOFF GOSWEILER, M.D. OF BALTIMORE.

When M. Compte's school of future philosophers become possessed of those divine attributes, which will doubtless result from their apotheosis, it is quite possible that they may be able to discover the psychical condition and the external signs of a defective moral organization, and be enabled from those data to place beyond conjecture the future honesty or dishonesty of any person who may be examined by them. Such a psycho-physiognomical examination would place the probity of applicants for positions of trust beyond the range of doubt, beside being an almost certain guarantee as to their future good behavior. A certificate from such a board of examiners would be a godsend to the bureau of Civil Service examiners, and insure absolute trustworthiness on the part of applicants for office, and would replace present testimonials of reputation, which, like epitaphs, are often as untrue as they are eulogistic. Those certificates would probably give the dimensions and ratio of the anterior and posterior lobes of the brain and other cephalic condition, facial indices of the character, force and intensity of moral consciousness and degree of ethical sensitiveness, all indicated as in a phrenological chart, with a general deduction displaying at a glance the various gradations of honesty from that which would be proof against a thousand dollar temptation to that which would be unassailable at twenty thousand.

But this philosophic apotheosis would only affect the status of the more respectable of those predisposed to crime, while the vast majority of offenders, who eschew such tame transactions as embezzlements and defalcations for more sensational burglaries and robberies, would never submit to such examinations. Doubtless it is possible that the new-light therapeutists might discover a method of reclaiming criminals and preventing others from vicious courses by inoculation, as Dr. Jenner secured a specific against small-pox. Were anything like this possible, what a boon it would be to the business community and the public at large. As there is, however, no immediate likelihood of such a desideratum, people must depend upon old methods in opposing crime, and must trust to appearances and recommendations, and those inclined to wrong will be considered honest as formerly until they prove themselves the reverse. But treating the subject with the degree of seriousness that it deserves, the condition of society as the result of crime and the various forms of error is one of the saddest and most anomalous circumstances connected with human existence. Vast multitudes of people in all civilized countries are, in consequence of vicious training, or an inherited defective moral sense, so constituted as to require but the slighest stimulus to cause them to err. Indeed, it may be almost assumed that all crimes are the result of a feeble moral consciousness, a species of ethical insanity, ranging in intensity all the way from weak promptings to do wrong to an irresistible propensity to crime. The law recognizes

this distinction and does not inflict judicial penalties upon ethical grounds or merely for the purpose of punishing a moral wrong, but rather for the repression of crime and the safety of society. The degree of moral responsibility of persons who are criminals in consequence of early associations and inherited traits is a question for ethical philosophers and theologians to discuss. Society is concerned with the crime, not its antecedents or producing causes, though it might with advantage study—and with the hope of a future solution—a problem presented to the jurist as the result generally of a defective social organization.

It is scarcely conceivable that ethical teaching can accomplish much good, when the moral sense is either partially depraved or almost extinct. Religion has done much in reclaiming the masses, but the evil is hydra-headed, and the vast majority of the vicious are as far removed from its sphere of action as they are defectively impervious to its benign influences. Remedial measures, so as to become effective, must be applied earlier. Not only after birth, but previous to it, as the foul taint of vice, like disease, is transmitted, and thousands come into the world with the germs of future crime contained in the embryo brain. That government could scarcely be considered arbitary that would adopt all available measures for the protection and well-being of society. Marriages between persons either of whom is a drunkard, or belonging to the criminal classes, or afflicted with a disease mental or physical, capable of being transmitted, or in such circumstances as would lead to the conclusion that their children would be improperly reared, might be prohibited. The effect of such a legislation for fifty years might be a moral revolution, and the disappearance would not be more marked than the better hygienic condition of the people, and their superior physicial and mental development. Such Spartan legislation, though not like Draco's laws, written in blood, would no doubt be strenuously opposed by those mainly affected by it, who, it is but too probable, would feel indisposed to sacrifice themselves, so that future Americans might have the morals of a divine and the form and features af an Apollo Belvidere. The veneering of refinement and quasi morality, the result of a defective civilization, though beneficial to society, is rather a negative good than a positive virtue. If crime has decreased among those having a bias toward it, as a consequence of education, it is rather because they do not consider it necessary than that they think it wrong, and it is but seldom that even the most hardened criminals do wrong, simply from preference. The taint of vice is in the blood, and as a general thing education only makes the person adverse to the grosser forms of evil and lessens his motives to do wrong by enlarging his sphere of action.

When secular and compulsory education shall have refined these brutal minds, when a much-needed foresight shall have multiplied the resources of the labor-market, when a purer atmosphere shall circulate in the lower social grades, society will have done all in her power to suppress the germs of the disorder by which she is being consumed. Then she will be able, with less scruple, and in a more enlightened spirit, to apply to evils already diminished by hygiene, the rational process of less brutal and more efficacious surgical and therapeutical methods.

Clinical Notes.

Dr. D. Genese, of Baltimore, writes:—After using carbolized resin in dental practice for nearly ten years, I was induced to try it in a case of in-growing toe-nail of a very acute form, in which case it has given permanent relief, arresting the pain and inflammation after the first application. Since then, several cases have been treated successfully, the patients all saying relief was immediate. I have given some of the preparation to several medical gentlemen of this city, and should like to hear what success they have had with it.

It is made with Calvert's pure carbolic acid and pure French pine resin. Great care is needed in not having any free acid. Messrs. Lilly, Rogers & Co. have offered to prepare the carbolized resin according to formula I have given them; and anyone wishing to try this can obtain it at their store.

One drop is sufficient to apply at a time, and a pointed orange-wood stick is best to apply it with; upon two or three applications all trouble disappears; as, after the first application has been on twenty-four hours, the nail can be lifted and a pad of lint placed under without pain.

Correspondence.

To the Editors of the MARYLAND MEDICAL JOURNAL.

DEAR SIRS:—Is there no relief from the plague of patent medicines or their vendors? By patent medicines I mean such as are sold under a distinctive name, for which no reliable, exact formula of the ingredients or mode of preparation is published, so that if necessary or desirable it could be at once made for comparison; and such as are advertised in other than standard medical Journals. If the exact formulæ are published, there is of course no necessity of purchasing (if it is good for anything) a preparation which any competent druggist can easily dispense fresh in a few moments. The impudence and brass of these medicine agents is phenomenal. They take up our time; ask us to lumber our shelves with their quack remedies, and worse than all, request our signatures, and it is well known that several physicians have given theirs, either from greed of gain or desire to advertise.

It is quite time that the different medical societies adopted some hard and fast line over which we might not step without being dropped from the roll of members.

Such a line might be that: To invite or allow laymen to be present at surgical operations, except when their attendance was absolutely required for the welfare of the patient, or to in any way encourage report of surgical operations or cases in any but strictly medical Journals, is declared to be an offense for which the penalty should be public reprimand for the *first* offense, or expulsion for the second.

To give certificates or testimonials as to the efficacy of any preparation intended for medical use, whether medicines, mineral waters, or external medicines, which are sold in bottles, packages or piece, under any distinctive name, the manufacture or source of which is in any sense a monopoly, shall be declared contrary to the spirit of medical ethics, and the member so offending shall be publicly reprimanded for the first offense and dropped from the roll for the second offense. Decisive action of this kind on the part of the medical societies, would soon control such exhibitions as we have recently had of a dozen signatures to a quack remedy, and make the medical profession really an honest profession, not a disreputable trade, whose motto is "anything to make money."

As for the druggists, the moment physicians combine to boycott, any and every one who refuses to agree not to prescribe or sell any medicine or medicines for internal use (more than a simple cathartic) without a physician's prescription, and not to treat any case of venereal disease, the evil is *ended;* provided vigilant watch is kept that this agreement is carried out in good faith. Plenty of good druggists can be found who would make such an agreement, and abide by it. All that is necessary is for the physicians to *combine*, *organize* and *act*.

It would be a reflection on the intelligence of any reputable physician to go at length into the reasons why in the name of decency, expediency and right, the sale of proprietary medicines should be discouraged; we know they are in the immense majority of case cheap and nasty, unreliable, if not absolutely harmful, when sold and used indiscriminately as they are designed to be. A future age will consider the sale of proprietary medicines as much a swindle, and from an economical standpoint, a loss, as we now consider lotteries or gambling, both of which were formerly allowed or defended.

W. B. PLATT, M.D.

165 Park Ave.

MESSRS. EDITORS—*Dear Sirs:*—I think, with you, that *it is high time that quackery be suppressed*, when such cards as I enclose, are freely distributed in the city of Baltimore.

I happened to be at a printer's and saw some thousands being struck off, and secured the enclosed for your inspection.

Yours truly, D. GENESE.

"MRS. DRUSILLLA, the original Gipsy queen, herb doctress and Egyptian fortune teller, seventh daughter of the third generation, the only true fortune-teller now traveling—late from Egypt. Mrs. D. possesses the most wonderful power to foretell events of your life. She tells you your past, present or future by the planet you were born under, or by the physiognomy; also the names of friends or enemies, and of your future companions; also what business you are adapted to. She can tell where to find anything strayed or stolen. She can tell you about absent friends, whether living or dead. She can tell you whether your companions are true or false, also what part of the country is luckiest for you. Thorough satisfaction given or no

charge. Mrs. D has traveled all over the continent and met with great success, and is now willing to be consulted on all diseases, such as blood diseases, bilious complaints, diseases of the stomach and heart—rheumatism in all its stages. Will guarantee perfect cure of coughs and colds, weak lungs, and consumption in first stages. Also swellings, bruises, nervousness and weak mind, and will warrant a cure of all female complaints, and others too numerous to mention. Cures performed either by herbs or laying-on of hands. Mrs. D. is willing to give trials to all who doubt her, either by electricity or herbs. She was born with a natural gift, and was not taught as many of the profession are. Thousands of clairvoyants, mediums and fortune-tellers may have visited your city, but none can equal Mrs. D., who has been gifted by God with a wonderful gift of nature, to unravel the mysteries of your future. Please call and see. Advice free concerning diseases—the poor to be considered. She will be here but a short time, and all wishing to see her must call early, at south-east corner Park and Lexington streets, first floor. Don't ring. Price 50 cents to $1.00."

Society Reports.

PROCEEDINGS OF THE MEDICAL SOCIETY, DISTRICT OF COLUMBIA.

STATED MEETING HELD DEC. 3, 1884.

(*Specially Reported for the Maryland Medical Journal.*)

The Society met with the President, Dr. Garnett, in the chair, Dr. W. H. Taylor, Secretary.

Dr. W. W. Johnston read a paper on

MILD CASES OF TYPHOID FEVER.*

In the discussion which followed:

Dr. Mackall said that the thanks of the Society were due to Dr. Johnston for bringing forward for discussion the very important subject of fever, but thought the doctor in error in assuming that the form of fever, which for several years has been so prevalent in this District, and all other parts of this country, is always typhoid fever, or, in other words, a specific fever dependent upon the reception into the system of a peculiar and specific poison derived only from other cases of typhoid fever. The mild and severe cases differing only in degree and not in essence.

Of the existence of such specific fever authorities leave no question, but while not denying the correctness of this opinion he hesitated not to say that as yet they rely mainly upon assumptions that may be questioned. And before he could give it his entire acquiescence pathologists must first discover its specific germ, prove its capacity for reproduction by inoculation, and still further prove the impossibility of its development from other causes.

But while in doubt as to this point his observation and experience had convinced him that there is a fever due to a form of abdominal catarrh, and that while this fever in many cases presents many of the symptoms and pathological changes met with in typhoid fever there is a distinction between the two, and that it has its origin independently of a specific poison—the outcome of other cases of typhoid fever. Its cause is, he believed, due to climatic conditions, possibly and probably in many cases connected with some insidious form of malaria, and that this form of fever is the one now prevailing in this District, and not only here, but all over the entire country, and probably to the same extent in foreign lands.

He was free to admit that in many cases the similarity between this fever, which we will call mucus, and the so-called specific typhoid fever is very striking so that many intelligent and experienced physicians have failed to distinguish and recognize it. And while there are many reasons for supposing that in many cases it is etiologically dependent upon some insidious form of malaria and in various ways shows a resemblance to Paludal fevers, nevertheless, as a rule it possesses marked distinctive features of its own, and requires a different mode of treatment.

He regretted that he was not able, to-night, to present in proper shape and form the reasons that had led him to these conclusions. He could only, in a very desultory way, first point out some of the particulars wherein this fever differs from typhoid fever proper, and specify the distinctions between it and our old marsh fevers, and then allude to some of the cardinal points in its treatment.

Mucus fever is not infectious. Typhoid is. There is no fixed period of incubation in mucus fever.

Typhoid attacks by preference the strong and healthy; mucus, the feeble and those whose health is below par.

Typhoid fever prevails mainly between the years of fifteen and thirty-five. Mucus

* An abstract of this paper could not be secured for publication.

more generally singles out the young and the old.

Typhoid confers a certain immunity against subsequent attacks. Mucus leaves the patient with marked tendency to recurrence of the disease. Year after year for several years he had attended the same patients with spells of the same fever. He was able to recall many instances of this kind. As its names implies, typhoid fever produces a marked prostration of the mental faculties. In mucus fever the nervous system is comparatively but little disturbed.

In typhoid diarrhœa and typanitis are generally present. In mucus these symptoms are more frequently absent. Hemorrhages from the bowels are more frequent in the former, and in the latter perforation is extremely infrequent. The same may be said of bed-sores.

In typhoid the region of the ileo-cæcal valve is the locality where pathological changes are especially found. In abdominal catarrhal fever we generally find in the stomach and in the duodenum the more decided evidences of disease, consequently nausea, vomiting, jaundice, hiccough, etc., are more usually encountered in the latter.

The treatment best adapted for one is often prejudicial in the other.

In one the powers of life need to be sustained earlier, and more decidedly by nutriment and stimulants, nervines, anodynes and antipyretics. In the other stimulants and almost all drugs administered per orem are contraindicated and generally increase fever, and aggravate all the symptoms.

In mucus, alimentation is often best carried on by enemata. In typhoid intestinal feeding often proves disastrous by irritating and increasing the congestion of the mucous membrane of the intestines.

In abdominal catarrhal fever existence is not only maintained but the body weight sustained for weeks by an amount of nourishment that would be inadequate to keep alive those suffering from typhoid fever.

In mucus fever relapses occur much more frequently, and even after convalescence seems well-established the slightest imprudence, especially in diet, is followed by a return of the fever.

Mucus fever is apt to leave the gastro-intestinal mucous membrane in a state of chronic catarrh, which renders its victims valetudinarians for years. Indeed it is questionable if perfect health is ever regained after a severe attack.

Abdominal catarrhal fever, when early submitted to judicious management, is very frequently aborted.

Enteric fever with the changes in Peyers' patches, solitary and mesenteric glands, by the presence of a so-called specific poison cannot be prevented from passing through certain stages occupying fixed periods of time.

The form of fever to which I refer runs no definite course, but may be prolonged almost indefinitely if the catarrhal condition of the gastro-intestinal mucous membrane is kept up by improper food and treatment.

The distinctions between abdominal catarrhal fever and the frank and genuine forms of marsh fever need occupy the attention of the Society but a moment or two.

The latter prevails in the neighborhood of marshes, low-lands, jungles and river courses. The former has no particular abode. Well and truly has it been said that "It prevails from the Rocky mountains to Maine." It is met with in the North and the South, in the East and in the West. We find it in the palaces of the rich as often, if not oftener than in the habitations of the poor. Alike in the impure atmosphere of large cities and in the more salubrious air of villages and towns; amid the bracing breezes of the sea-shore, and the rude homes of the mountaineers.

Unlike the intermittent and remittent fevers of former times, it is uninfluenced by frosts or even the extreme winter's cold.

Unlike them it shows no tendency to be followed by periodic attacks of chills and fever.

Enlarged spleens and livers are not its usual attendants, but, as has been already stated, it is prone to leave the mucous membrane in a state of chronic catarrh.

It pursues its course uninfluenced by heroic doses of quinine and other antiperiodics when administered per os. On the other hand these drugs when so administered seem to be specially injurious.

It is rarely subdued or even benefitted by mercurials and purgatives and anti-febrile mixture. Indeed these, and all other medication directed to the alimentary canal instead of doing good, generally aggravates the disease and renders it more and more difficult to distinguish it from enteric fever proper.

In one respect it closely resembles yellow fever, for if you would avoid doing harm, you must scrupulously keep your hands from your prescription book and devote all your faculties to finding out some form of bland nourishment which will be the least offensive to the diseased digestive organs, deprived of all their physiological functions, and to the restoration of the congested membranes by counter-irritation and by inducing a determination to the skin through external agencies, and in suitable cases by bringing the system under the influence of quinine, either by friction or hypodermic injections. In no other disease is the patience and skill of the physician so sorely tried, for he must stand firm against the importunities and interferences of relatives friends and neighbors, and their urgent solicitations for drugs, stimulants, nutrition and improper food, not for a day, but often for weeks, and sometimes months. He must not swerve from his course, although he realizes that the confidence of both patient and friends is being shaken; that they are listening to the suggestions and criticisms of the ignorant and the officious, and treating his opinions and advice with cold respect.

Dr. Mackall, further said that he thought that the theory advanced by Dr. Johnston, to the effect that intermittent, remittent, and all other forms of continued fever were the result of a specific typhoid fever poison, was entirely erroneous, and he had no doubt but that during the discussion that would follow, many facts would be brought forward which would entirely refute his position. He then asked Dr. Johnston if it would not be more rational to conclude that typhoid fever was due to malaria than to suppose that malarial fever was due to a specific typhoid fever poison? That he, (Dr. Mackall) could understand that at one period malaria might induce pathological changes in the mucous membrane of the upper portion of the alimentary canal, and thus give rise to a fever attended with decided gastric and duodenal irritation and disturbance—the type now prevalent. At another period, say ten years hence, it may involve the mucous membrane in the region of the ileo-cæcal valve, causing a fever characterized by all the symptoms and with all the pathological changes of typhoid fever. Further, he believed that these changes, viz: engorgement and ulceration of Peyer's patches and the solitary glands—the enlargement and further pathological changes of mesenteric glands and spleens, and indeed of all other organs were erroneously supposed to be due to the presence of a specific deposit, but was induced by the inflamed condition of the mucous membrane of that particular locality. The engorgement, ulceration and other changes of the glandular bodies being the result of the passage through them of the impurities of the blood, and its high temperature, and of the absorption of flammatory products. Finally, he said that he thought that the only rational explanation of the sudden and very decided improvement which took place in the cases referred to by Dr. Johnston—in which judicious dieting and treatment had been resorted to—was due to the fact that the inflammation of the mucous membrane had been either thereby arrested before it reached the region of the ileo-cæcal valve, or so moderated it that ulceration, &c., in the Peyer's glands, &c. did not ensue; and it seemed clear that the fatal results observed in the other cases referred to, in which food of the most improper and dangerous character had been indulged in, was only to be explained upon the supposition that it caused an extension of the inflammatory changes to the lower portion of the small intestines and thereby induced the destructive processes found after death in the glands of that locality. * Therefore, the following corollaries may be deduced from what had been stated:

That continued fever is due to various causes, giving rise to abdominal catarrh. In some, the exciting cause may be taking cold, improper food, malaria; in other cases, sewer gas, emanations from foul dung-hills, impure water, and especially water impregnated with fæcal evacuations, &c., &c., may originate the fever.

The type of the fever will be influenced by the portion of the alimentary canal involved. When the gastro-duodenal membrane is mainly affected, the form will be more decidedly intermittent, and remittent, without marked tendency to disturbances of the sensorium. When the region of the ilium is the part attacked, the fever will be markedly typhoid.

[*To be Continued.*]

* Omitted in the remarks of Wednesday last, and the corollaries have been added.

Editorial.

THE NECESSITY FOR CONCERTED ACTION UPON THE PART OF THE MEDICAL PROFESSION IN AN EFFORT TO SUPPRESS QUACKERY IN MARYLAND.—If proof were needed to demonstrate the necessity for concerted action upon the part of the medical profession in an effort to suppress quacks and quackery in this State, the facts which have appeared in the daily papers in connection with the "Star Cough Cure," manufactured in this city, seem to us to be sufficient. The profession and the public have been treated to a nauseating dose of this so-called remedy as it appears heralded in the columns of the daily press endorsed by Governor, Mayor, Health Commissioner and a string of doctors and lesser lights in city politics, all testifying to its purity, harmless nature and curative properties. Has there ever before been such a display of bombast and brazen insincerity presented to the people of this city?

When a corporation, enriched by its nostrum trade, can deliberately entrap the highest officials of State and city, and a number of our own profession, and levy upon their positions and influence for an endorsement of their proprietary medicine, we must believe the time has come when concerted action upon the part of the profession should be taken to resist such influences at work in our midst. Can the profession pass by in silence such an attempt to prostitute public and professional opinion into a support of the claims of a remedy which can have no other merit than that assumed by its proprietors, whose sole object is to create a market for its sale? We think not. The profession has a duty to perform in this matter. It is due the public and it is due ourselves as the custodians of the public health, as the medical advisers of the vast majority of the citizens of this community, that a general meeting of the profession shall be held and some action taken repudiating in emphatic language this assumption of a wealthy and boastful corporation. If the Health Commissioner of this city can use his important office to affirm in the most public way that a secret nostrum "contains no mineral matter, poisons, opiates or emetics; that it combines in a unique and effective manner approved curative agencies which are relied upon by the faculties of the different schools of medicine with other valuable vegetable ingredients, which combination, to my knowledge, has thus far not been used for this purpose, and which in its action happily supplants the objectionable and not unfrequently harmful features of other cough mixtures," we think it is the duty of the profession as a body to repudiate in the same public manner this action of one whose position and duty as a public servant demand a higher service. The action of this same official has not only dragged his high office into the mire of quackery and humbuggery, but it has so lowered the professional *esprit de corps* that a number of physicians have been dragged into the snare so adroitly planned by cunning and designing capitalists. When we contemplate this adroit scheme to debase and belittle a profession, which is held in high esteem by respectable and thinking people, we are amazed at the audacity and boldness of the men who seek to build fortunes upon chicanery and assumptions. Shall we then submit to such practices without raising our voices against the motives and acts of this huge monopoly which is advertising our city throughout the entire civilized world as the grand centre of the nostrum trade? We cannot think the medical profession of Baltimore is dead to all sensibility and pride. The profession here numbers too many men of talent, ability, courage and high professional honor not to feel and resent this indignity placed upon them. Let us then come together as a body and officially and publicly repudiate the action of those men who have lowered the status of medicine by upholding a scheme to foist upon the public a remedy manufactured and sold as "a *prompt*, *safe* and *sure cure* for coughs, hoarseness, colds, sore throat, quinsy, pains in chest, croup, asthma, whooping-cough, influenza, bronchitis and other affections of the throat and lungs."

POST-GRADUATE INSTRUCTION AT THE UNIVERSITY OF MARYLAND, SCHOOL OF MEDICINE.—The Faculty of Physic of the University of Maryland announces, in a prospectus recently issued, that it has perfected arrangements for post-graduate instruction upon the following subjects:

Laboratory Instruction in Chemistry and Urinary Analysis, by Prof. Coale and David T. Day, Ph.D. Practical and Surgical Anatomy, by Randolph Winslow, A.

M., M. D. Operative Surgery, with Bandaging, by Walter B. Platt, M. D., F. R. C. S., Eng. Normal and Pathological Histology, by W. T. Councilman, M. D. Obtetrics, by L. Ernest Neale, M. D. Diseases of the Eye, by Herbert Harlan, M. D. Diseases of Women, by Wm. P. Chunn, M. D. Diseases of the Ear, by Hiram Woods, A. M., M. D. Diseases of the Nose, Throat and Chest, by Frank Donaldson, Jr., M. D.

The courses will begin about the 20th of March, and new classes will be formed as often as desirable.

In addition to these courses daily clinical lectures are given in the hospital by the Faculty and also at Bayview Hospital by the visiting staff.

The courses average about six weeks in length with a charge ranging from $10 to $15 for each branch.

Further from the India Cholera Commission.—It will be recollected that in their preliminary report (see the Journal of Feb. 7th) Drs. Klein and Gibbs denied Koch's statement that the comma-baccilli were found only in the intestines of cholera subjects, or that they were invariably present, even in typical cases of cholera, or that they were found in the tissue of the intestine, or that they were inoculable upon the lower animals. We have now (*Brit. Med. Jour.* Jan. 31) a supplementary report from a member of the Commission—Dr. Klein—which deals with another first adduced by Koch in proof of his theory and which *seems* to overthrow it. During his visit to Calcutta a year ago, Dr. Koch discovered in the water of a pool or pond around which the huts of the natives were clustered, and whilst a local epidemic of cholera was prevailing in these very huts, numbers of his comma-baccilli; the number was large during the height of the epidemic, but greatly diminished when it had subsided. He thence inferred that water was the medium by which the contagion was conveyed. Dr. Klein repeated the examination in the very same locality. Three ponds—these are chiefly excavations of earth made by the natives in procuring mud with which to daub their huts, and which became subsequently filled with water, then serving for all the domestic uses of the neighboring residents, including drinking, bathing, washing clothes and utensils, deposit of excrement, etc.—were examined with reference to the presence of comma-baccilli. One of these three was the one upon which Koch's observation had been made. Comma-bacilli were found in all three. Yet among the five hundred or six hundred families living around the pounds only one case of cholera had occurred, and that at the Koch pond. In three houses, not far from one of the other two, there had occurred eight cases; but these were occupied by well-to-do people, who had a pure water supply of their own, and never went near the pond.

Now we have here examples of people using for an indefinite period water contaminated with the comma-baccilli and yet developing no cholera. It appears therefore as if Koch had reached a hasty conclusion in inferring from the *mere presence* of the comma bacilli that they were the cause of the cholera which prevailed. We shall await with interest further investigation in this direction, and are therefore glad to learn that Dr. Koch will revisit India as soon as his duties in Berlin permit, for the purpose of continuing his studies in bacteriology.

The Second Annual Announcement and Catalogue of the Baltimore Polyclinic and Post-Graduate Medical School, recently received at this office, gives evidence of good work during the first year of its existence. The announcement for the session of 1885 states that the Faculty of the school feels encouraged by the results of the first session, which exhibited more substantial success, both as to the amount of clinical material and the number of students in attendance, than could reasonably have been expected, when it is considered that the year was far advanced before the clinics were organized.

During the year, 5,098 individuals were treated. The patients made an aggregate number of about 20,000 visits. During the year, 27 students and physicians matriculated at the institution and received instruction in one or more branches. The States of Wisconsin, North Carolina, Virginia, Pennsylvania, South Carolina, Florida and Maryland were represented. Seventeen of the twenty-seven students were graduates of medicine.

During the present year it is stated that the clinical advantages of the school will excel those of the past year. The announcement says:

"It is believed by the Faculty that the

school is destined to perform a valuable service to students and practitioners of medicine. From the large number of letters received from physicians throughout the country, especially in the south and west, it is thought that this character of medical teaching will be sustained by practitioners who feel the need of clinical instruction in special departments. The Polyclinic and Post-Graduate School is not designed to make more but to make better practitioners. Its chief aim is to impart clinical instruction in the most practical manner possible. The student is brought in direct contact with the patient; he is enabled to examine each case in detail; he is taught to become familiar with the diagnosis and treatment of disease, by an observation of the disease itself as it is presented to him in the cases brought under his immediate attention. The various methods of diagnosis and treatment adopted by the specialist are fully explained to him, and he is carefully drilled in the practice of these methods. Independent of the clinical study of disease, instruction in each department is aided by diagrams, models and drawings explanatory of the subjects under consideration."

We observe that the vacancies occasioned by the resignation of members of the Faculty have, for the most part, been filled by new appointments. A Board of Directors, composed of some of the most distinguished members of the profession in this city, has been made a new feature in the organization of the school.

It appears from the announcement that the results of the first year's work at the Polyclinic have been fully as good as was anticipated by the present members of its Faculty and upon the strength of this success a vigorous effort will be made place the school upon a strong and permanent basis.

Miscellany.

The Treatment of the Umbilical Cord.—Credé and Weber (Leipzig, in the *Archiv. f. Gynak, Edin. Med. J.*) set themselves to answer the question, How is bleeding from the divided cord to be obviated? and, How is inflammation and its results, of the fœtal portion, to be prevented? In the first place, they state that they are dissatisfied with the ordinary methods of secural by by tape or linen; but both from clinical experience and as result of experiments made on cords post-partum, they recommend strongly the use of elastic ligatures, as suggested by Budin, and as used by them in Leipzig for the past eighteen months, with perfectly satisfactory results. The ligature used is two mm. thick, and is tighly wrapped round the cord, tied, and again taken half round and retied. As by this means the operator can be perfectly certain that there will be no bleeding, the point ligatured should be close to the skin on the cord, as, according to the writers, the shorter the portion left attached to the child, the less chance is there of traumatic inflammation. The after-treatment simply consists in keeping dry wadding round the stump, and carefully drying after the child has been bathed. Since the above treatment has been followed in the Leipzig Maternity, there have been no cases of umbilical disease.—*Journ. of Amer. Med. Ass'n.*

A Remedy for Street-noises.—Owing to illness and long residence in tropical climates, I some years ago became morbidly sensitive to noises of every kind, and procured complete relief in the following way: I placed some spermaceti ointment in the centre of a little square of thin limp cotton, brought the corners together, tied them with thread, and inserted one of the little plugs well into each ear, and found, after a little kneading and gentle pressure, that I was absolutely deaf to all ordinary noises, such as the loud barking of dogs, and the rumbling of carriages in the street.

A couple of points must be carefully attended to. The ointment must not be too soft, the quantity about the size of a small pea, and the little bag must be somewhat larger than its contents, so as to allow the plug to take the shape of the auditory canal. If the bag be too small, or its contents too large, it cannot be inserted into the ear, and if applied only to the orifice it fails entirely in its object.

This little experiment is easily tried, and a daily experience of over twelve months warrants me in saying that it will be valuble in the sick room.—*British Med. Jour.*

Excessive Sweating.—Sponging the surface of the body with a solution of quinine in alcohol—one drachm to the pint—is now recommended for excessive sweating. It is a remedy that has long yielded us good results.—*American Practitioner.*

Treatment of Gout.—In all the forms of gout Dr. Granville has given the following formula with such success that he recommends its trial by others. He never gives colchicum:

℞	Ammonii chloridi,	ʒ iv,
	Potassii chloratis,	ʒ ij,
	Glycerini,	fl. ʒ xij,
	Tr. iodini,	fl. ʒ ij,
	Aqua ad.,	fl. ʒ xij. M.

Dose.—Two tablespoonfuls four to eight times daily.—*Med. Times.*

Calomel in Diphtheria.—I can safely say that in a bad case of croup, with which I was much more familiar forty or fifty years ago than I have been in later years, I always found calomel a good and useful remedy. I can recall one case, the very worst I ever saw recover, in which death was momentarily expected for three long weary days and nights, when, having given ninety-four grains of calomel, a large, dark-green alvine evacuation was followed by an immediate amendment and cure, and I saw the same infant grow up to be a young woman, dying at twenty-two years of phthisis. But is not mercury supposed to have a peculiar effect in detaching the epithelium of the mucous membrane?

What pleased me most in the history of the cases was to find that in one of them a solution of the bichloride seems to have been used with advantage, for during the last six months I have treated every case of thrush or muguet, some ten or twelve which came under my care, by brushing the affected part over daily with a solution of the bichloride hydrarg., one grain to the ounce of distilled water. It acts more effectually and is neater in application than the sol. arg. nit. which I have hitherto used.

In a case of typhoid pneumonia in an aged feeble woman I removed by their daily application a thick crust of *cryptogame du muguet* which was fully one-eighth of an inch thick. My experience in pure diphtheria has formerly been very limited, but it strikes me that by the use of Jansen's crystallized pepsine, if so powerful a preparation as is represented be used as a solvent and followed by a solution of the bichloride as a germicide, we would have a useful and neat local application; but I must say later the old rule in prosody —"*usus te plura docebit.*"—*Dr. James Martin, in London Medical Press.—Louisville Med. News.*

A Diuretic Mixture.—Dr. Joseph Mullone, of Lyons, Ind., writes to us that he has treated a number of severe cases of an aansarca, most of them of distinctly malarial origin, and has been much pleased with the action of the following formula:

Compound spirit of juniper,	1 pint.
Sulphate of iron,	2 drachms.
Acetate of potassium,	½ ounce,
Fluid extract of digitalis,	2 fluidrachm.
Syrup of squill,	½ fluidounce.

Dose, a tablespoonful three times a day,

In severe cases the patient is to drink also a cold infusion of elder root.—*N. Y. Med. Journ.*

The Origin of Cholera Epidemics.—Dr. John H. Rauch calls our attention to the fact that he does not forget the history of cholera elsewhere than in the United States, but has distinctly stated that "Cholera is a capricious disease, and the history of its various pandemic extensions throughout the Old World affords occasional instances of a single introduction sufficing to inaugurate an epidemic."—*Med. Record.*

Pixene in the Treatment of Pruritus Vulvæ.—Locke, in a letter to the *Lancet*, recommends the following lotion for pruritus of the vulva:

℞	Pixene,	2 drachms.
	Glycerin,	4 drachms.
	Water,	6 ounces.

Neale, writing in the same journal, recommends a saturated solution of boric acid. —*N. Y. Med. Journ.*

The Influence of Potassium Bromide on Nutrition.—The favorable results obtained from the use of potassium bromide in different nervous affections, particularly epilepsy, leads one to conclude that the nervous functions are influenced by this drug. B. Schultze (*Zeitschr. fur Biologie*, No. 19) made a series of experiments on himself, taking the bromide in ten-gramme doses daily for some days. He found a large increase in the volume of the urine on the day the drug was taken. The nitrogen excreted was determined in the urine and fæces, but the influence of the bromide upon its elimination was not marked; the

sulphur, however, was found to be increased, and phosphorus diminished. The author, therefore, concludes that under the influence of this drug the metabolic activity of the nerve-centres is diminished, this being accompanied by a decided diminution of the nervous activity.—*Med. and Surg. Rep.*

A Simple Method of Washing Out the Bladder.—In the *Lancet*, October, 1884, p. 675, Mr. Buckston Browne describes a simple method by which a patient can wash out his own bladder. A diagram is given which helps to explain the action of the instrument. A simple bifurcated brass tube, without valve and stopcock, has one end fixed to a Higginson's syringe; the nozzle is fixed at the other end to a catheter in the bladder. The fluid is gently injected into the bladder by squeezing the ball of the syringe, whilst a finger is placed over the open end of the bifurcated tube; when the finger is removed the contents of the bladder escape, or fresh injections can be made into the bladder, and then allowed to flow away at pleasure. By this means a patient is able to wash out his own bladder with ease.—*Med. and Surg. Rep.*

For the sweating of phthisis, Prof. Bartholow advises:

℞. Acid. gallici. drams ss
Ext. belladonnæ, gr. ij
Ft. pil. x.
Sig. Two pills at bedtime.

A favorite prescription of Dr. DaCosta in marked idiopathic anæmia is:

℞. Ferri sulph., drams j
Potassii carb., drams j
Ft. pil. No. xl.
Sig. One after meals for first week; increase dose in second week, etc.

If the patient is a female, suspend treatment during menstruation.

Erratum.—In Dr. McSherry's paper on treatment of Insanity it was said that hot baths should be used varying from 82° to 86° F., which should read *warm baths*, from 86° to 96° F.

The 52nd annual meeting of the Medical Society of the State of Tennessee will be held at Nashville on the 14th, 15th and 16th of April.

Medical Items.

The Legislature of North Carolina has made it a misdemeanor for any one to practice medicine in that State without a license from the State Board of Examiners.

The Sanitary Council of the Mississippi Valley will hold its seventh annual meeting in New Orleans on Tuesday, March 10th. It is expected that the attention of the meeting will be largely given to the subject of cholera.

Muriatic acid is said to prevent the development of intestinal worms.—*Med. Record.*

The American Medical Association will meet in New Orleans on April 28th.

Prof. Robert Bartholow, of Philadelphia, has been elected a corresponding member of The Société Médico-Practique de Paris.

It is said that Dr. Koller, the discoverer of the anæsthetic properties of cocaine, has recently fought a duel. His antagonist, one of Billroth's assistants, received a wound that may prove fatal.—*Boston Med. and Surg. Journal.*

The total valuation of charitable property in the State of New York on Oct. 1, 1884, was $46,856.670. The receipts and disbursements were both about $650,000 more than during the preceding year.

It is stated that *The Index Medicus* will be published by Geo. S. Davis, of Detriot. The publication of this work was suspended about the close of last year for want of support.

Billroth has operated eighteen times for resection of the stomach.

Dr. William Braithwaite, the editor and founder of *Braithwaite's Retrospect*, died at his home in Leeds, England, on January 31st. He was born in 1807, and was therefore in his seventy-eighth year. He began the publication of *The Retrospect* in 1840.

The Comma Bacillus—A Koch sure thing.—*Med. Record.*

Dr. P. Byrnberg Porter has been appointed editor of *Gaillard's Medical Journal*. Dr. Porter has had a large experience as a journalist, and is eminently qualified for this position.

Original Articles.

DOES TOBACCO PRODUCE AMBLYOPIA?*

BY W. FRANKLIN COLEMAN, M.D., M.R.C.S., ENG.
BALTIMORE, MD.

Formerly Surgeon to the Toronto (Canada) Eye and Ear Infirmary and Ophthalmic and Aural Surgeon to the St. John (N. B.) Gen. Pub. Hospital.

Mr. President and Gentlemen:—The question, does tobacco produce amblyopia, is on account of the universality of puffing and chewing the "fragrant weed" and the potency of tobacco as a poison, a very important one. Tobacco belongs to the family solanaceæ, which embraces such relations as hyosciamus, belladonna, stramonium and curiously enough the potato. Its important active principles are an alkaloid called nicotine and a volatile oil nicotianin. By burning tobacco an empyreumatic oil is produced, which, as found in the pipe of the smoker, is an active poison and appears to be nicotine attached to a true volatile oil (Christison). The proportion of nicotine in various specimens of tobacco is estimated from two per cent. to one part in ten thousand.

Von Boeck, on vegetable poisons, says: "It is from smoking tobacco that nicotine poisoning chiefly arises, the smoke itself containing the nicotine. A great deal of it accumulates on the lower part of the pipe, and the remains of cigars are much more impregnated with it than the parts fresh smoked."

The observations of Claude Bernard that nicotine at first produces contraction of the arteries, and later on the vessels become distended, agree with the views of Uspensky, who, from physiological researches, concludes that nicotine first stimulates, then paralyses the vaso-motor centres.

From personal experience and the literature at my command, I know of no more constant detrimental effect of the use of tobacco than more or less impairment of vision.

The use of tobacco is so frequently associated with drinking to excess that it is questioned by some whether tobacco alone ever produces defective sight or whether the alcohol is not the chief etiological factor. My own opinion is, tobacco of itself is not only the frequent source of amblyopia, but when combined with the habitual use of alcohol is the essential agent.

Dr. Webster, of New York, in an able paper reporting "twenty cases of amblyopia from the abuse of alcohol and tobacco," remarks: "That the abuse of alcohol alone or of alcohol and tobacco combined may produce impairment of vision no physician acquainted with the subject will, I think, venture to deny.

"Some, however, doubt that tobacco alone ever causes impairment of vision, and indeed it is difficult to demonstrate that it ever does."

Now, in looking over Dr. Webster's cases, it appears that all who used alcohol also *smoked* to excess. On the other hand, two who smoked to excess took so little alcohol that probably Dr. Webster would not claim it had any share in causing the defective sight; proving so far as his cases are concerned that tobacco alone impaired sight, while alcohol alone was not the cause of a single case of amblyopia, e. g. "Case 7.—C. McK., æt. 49, has smoked ten to fifteen strong cigars daily for ten years; occasionally drinks a glass or two of gin. Vision=$\frac{1}{6}$ each eye. Incipient atrophy of optic nerves.

Case 12, æt. 60; sight failing over a year. Has smoked a strong pipe most of his working hours for more than forty years. Has rarely tasted liquor. Vision=$\frac{1}{10}$ each eye. Brick-dust atrophy of both optic nerves. Ordered to stop tobacco and return in a week. Then vision in right eye doubled; in left eye all but doubled."

McKenzie, a worthy father in ophthalmology, pointed out the effects of tobacco in 1840. He wrote: "I have already had occasion to repeatedly hint my suspicion that one of the narcotico-acrids which custom has foolishly introduced into common use, namely, tobacco, is a frequent cause of amaurosis."

More recently Wordsworth, Critchett, Hutchinson, etc., have given much attention to the effect of tobacco, and maintain it gives rise to impaired sight and even blindness with or without ophthalmoscopic signs. Hutchinson, one of the best authorities on tobacco amblyopia, wrote in '67: "The first stage (one which is very transitory and perhaps often altogether omitted) is one of congestion, during which the optic disk looks too red. Then follows pallor of

* Read before the Baltimore Academy of Medicine.

the outer part of the nerve disk. During these stages the patient complains of dimness of vision merely. In a later stage the whole disk has become pale, even to blue milk whiteness, and later still there is advanced atrophy. The stages generally occupy from four months to a year. In many cases the patient becomes at length absolutely blind, but in others the disease having advanced to a certain point is arrested. There is from first to last no evidence of any disease of any structure in the eyeball, excepting the optic nerve. Almost always both eyes are affected and progress *pari passu*." Three-fourths of his cases recovered.

During a personal interview with Mr. Hutchinson at Moorfields, in 1875, he remarked he had come to think the effect of alcohol antagonistic to tobacco, as a cause of amblyopia, unless the alcohol is taken in such excess as to produce degenerative effects of the system. He had seen amblyopia more frequently and more advanced in smokers who abstained from than in those who used alcohol.

Dr. Berry, of Edinburgh, also holds a similar opinion. He cites two cases of tobacco amblyopia; one in a man of seventy, who had been a teetotaller for forty years; the other in a boy of nineteen, who did not drink.

Berry, in common with many others, has remarked that the sight often improves on the cessation of smoking without any other change in habit and without other treatment, frequently without the supply of alcohol being diminished.

Since 1867 Hutchinson and others have examined more systematically the field of vision and color-vision and have found the diminution for objects and color is particularly in direct vision, while eccentric vision remains relatively good.

The color-blindness is generally for red or green, the former appearing blue, the latter white, gray or yellow.

In thirty-seven cases of atrophy of the optic nerve, Hutchinson attributed thirty to the effects of tobacco.

In thirty-six cases of optic nerve atrophy Leber found color-blindness an almost constant symptom, the perception of color remaining intact in only three.

Berry says he has looked out for the symptoms of tobacco amblyopia in women for the last five or six years and has only met with them in three cases. These three women smoked to excess but did not drink.

Förster cites twenty cases in which each patient was a strong smoker, and only able to see very large type. In eleven of these cases marked improvement in vision was observed when the use of tobacco was given up without other treatment.

Among the authors in my possession, who express their full belief in tobacco amblyopia and amaurosis, are Scotch, American, German and French, viz., McKenzie, Wolfe, Gowers, Wells, Nettleship, Noyes, Williams, Stellwag, Schweigger, Grünfeld, Mittendorf, Mayer, DeWecker.

The only two authors I have who dissent from the general view, are Carter and Lawson (Eng.). Dr. Roosa, I am aware, also dissents.

Carter quotes a letter from Dr. Dickson, of Constantinople, to the effect that the consumption of tobacco in that city averages three pounds weight per head monthly, but amaurosis is a rare affection. He also quotes Dr. Hubsch, oculist, in Constantinople, who writes: "I have never attributed amaurosis to the abuse of tobacco."

Mr. Carter adds: "I have obtained the same kind of negative evidence from Egypt and India, and in the face of it I do not attach much importance to the fact that several patients who have suffered from severe atrophy have been great smokers. If a patient who consults me on account of severe atrophy is a smoker, I always advise him to lay aside tobacco." I cannot comprehend why Mr. Carter thinks it his duty to give advice, the necessity of which he does not believe in, unless he thinks the belief of others a stronger reason for his duty than his personal conviction, in which case he must hold his own opinion very feebly.

Mr. Lawson says: "I do not remember ever having seen a case in which the loss of sight could be fairly attributed to tobacco alone. There was always, in addition to the immoderate smoking, some other excess, such as intemperance or undue mental strain with loss of rest."

Since I have more particularly recorded cases, I find out of eighteen hundred and twenty-four eye cases, forty-six who had partial or total loss of sight accompanied by conditions similar to those noticed in tobacco amblyopia, viz., either no ophthalmoscopic or otherwise detectable change in the eye

or else hyperæmia, decoloration or atrophy of the optic papilla.

These forty-six cases may be thus classified: Males, 33; females, 13.

Cases referred to tobacco alone.....13
" " " tobacco and alcohol 9
" " " other causes.....24

Tobacco and alcohol.	Males	9.	Females	0
Tobacco.....	"	13	"	0
Other causes.....	"	10	"	14

Cases in which there was hyperæmia, decoloration or atrophy of disk:

Tobacco.....	Males	12.	Females	0
Alcohol and tobacco	"	9	"	0
Other causes.....	"	7	"	11

Cases in which there were no ophthalmoscopic changes:

Tobacco.....	Males	1.	Females	0
Other causes.....	"	3	"	3

In regard to these figures I would remark, although no case of pure alcoholic amblyopia appears, it may be accounted for by the fact that in every case the heavy drinker was also an excessive smoker—a rule which perhaps has few exceptions.

I must admit not having questioned females as to the smoking and alcohol habit, as they appeared to be as usual so free from such male virtues.

Again, in all the cases but one of tobacco and alcohol and tobacco, changes were noticed in the optic disk, as the patients had not consulted me in an early stage.

I will briefly refer to only four patients who had tobacco amblyopia and were not addicted to alcohol.

Case I.—J. T., æt 44, consulted me in Feb., 1883. His sight has been defective for eight months, and he is unable to see more than half a word at a time with either eye. The half on the nasal side only being visible; vision is one-half in left and one-third in right eye; outer half of each optic papilla pale. Has smoked six pipefuls daily for the past fifteen years.

Advised to stop tobacco, and strychnia prescribed. Returned in two months. Said he had followed advice, and the sight was quite restored.

Case II.—H. O., æt 21; Dec. 28, 1883. Says both eyes have gradually failed during the past fifteen months, and can now barely distinguish light. Has for four years smoked six to seven pipefuls daily, and chewed one-fifth pound of tobacco weekly. There is advanced atrophy of both optic disks; no symptoms of brain or spinal disease; no history of syphilis; health good. Strychnia m. iv (grs. iv. ad. ℥ i) b. d. hypodermically, and increase m.j. daily; stop tobacco. Strychnia spasm was not felt till the dose reached gr. $\frac{1}{8}$, and then only occasionally. Vision remained the same after one month's treatment. Feb. 4, 1884, ℞. strychnia gr. $\frac{1}{12}$, t. i. d. by the stomach, and gradually increase the dose. Feb. 8, 1884; apply galvanic electricity three minutes daily to each eye, placing one electrode to the closed lids and one to the temple or nape of the neck. Feb. 27, 1884; taking strychnia gr. $\frac{1}{8}$, t. i. d. by the stomach, and feels spasm only rarely. Vision each eye increased to $\frac{1}{10}$. April 7, 1884; discharged with vision each eye $\frac{1}{10}$, and able to see his way about well. Then learned the patient had only diminished the amount of his smoking.

Case III.—J. McK., æt 31; sight failing three months; vision either eye = $\frac{1}{17}$. Has smoked since eleven years of age, and for three years past ten pipes a day. Takes a glass or two of whisky not oftener than once in several months. Both papilla (optic) hyperæmic. Stop tobacco; have temples cupped and take K. I. Jan. 5, 1881. Patient returned; has stopped tobacco; has gained twelve pounds in weight, and vision has increased from $\frac{1}{17}$ to $\frac{1}{8}$ in each eye; outer half of disks now pale. Jan. 20, 1884; white atrophic lines on disks and along retinal vessels (perivascular atrophy); vision the same. ℞. Strychnia.

Case IV.—Oct. 22, 1879. W. S., æt 21. Noticed nine months ago in school he could not see to read with the right eye, and six months ago noticed the same defect with the left, but two weeks later could see to read fairly well. A week later still the eyes again failed. Has smoked six to eight pipefuls a day from the age of fifteen until two years ago, and since three to four pipes daily. Is anæmic and nervous, but considers his health pretty good. Right eye counts figures at six inches on temporal side only. Vision L. E. = $\frac{20}{140}$ = No. 16 Jaeger. Eyes normal in appearance unless there is some engorgement of retinal veins. ℞. *Strychnia hypodermically.* Discharged after nine days treatment, with vision of right eye increased eight times, and doubled in the left. ℞. Continue strychnia by the stomach.

Allow me to cite a case which seems to strickingly confirm the view that alcohol counteracts the effects of tobacco.

July 12, 1884. C. N., 31, remarks his sight has been failing for six weeks. Has smoked from six to eight pipefuls of tobacco a day for the past seventeen years, and has been a hard drinker for eight years until three months ago, since which time he has abstained completely. He volunteered the remarked that "I think stopping spirits suddenly caused my sight to fail." His vision had always been good up to six weeks ago (*i. e.*, six weeks after giving up spirits). R. E. V. = $\frac{20}{20_0}$ = 16 J. L. E. V. = $\frac{20}{200}$ = 16 J.; refraction normal; temporal half of each papilla discolored. ℞. Strych. gr. $\frac{1}{30}$ t. i. d.; stop tobacco. July 8, 1884. Has smoked only three pipefuls since 12th. R. or L. E. V. = $\frac{20}{100}$. ℞. Strych. gr. $\frac{1}{30}$ t. i. d. Sept. 26. R. or L. E. V. = $\frac{20}{40}$ = 2 J. 6th, Rep. Oct. 9. R. E. V. = $\frac{20}{40}$, L. E. V. $\frac{20}{30}$ ℞. Strych. gr. $\frac{1}{15}$ t. i. d.

It may by some be maintained that impaired sight, the use of tobacco and the wearing of leather boots, for instance, are coincidences, "only that and nothing more." Medicine is not so exact a science that we can afford to be dissatisfied with proofs of the causes of disease, that may be little short of mathematical certainty. The proofs of the etiology of any disease seem to me not more conclusive than those which show amblyopia is produced by the use of tobacco.

Beau describes eight cases of angina pectoris in which the attacks ceased when smoking was stopped, and returned when the patient began to smoke.

Most of you are doubtless familiar with the tobacco heart.

Erb, of Heidelberg, says: "Various authors adduce excessive tobacco smoking among the causes of tabes dorsalis."

These are a few instances among the many in which tobacco smoking is believed to produce decided effects upon other parts of the organism, and very convincing evidence is not wanting to prove it frequently causes functional defect of sight, and occasionally genuine atrophy of the optic disks.

When we find in common with so large a number of competent and conscientious observers, that impaired vision (accompanied or not by apparent changes in the optic nerve) so frequently occurs without any cause to which it can be attributed, except the use of tobacco, and that the sight so generally improves when it is given up without other treatment, or change in the habits or surroundings of the patient, we can scarcely hope for stronger evidence of the cause of the amblyopia.

The comparatively few who disbelieve in tobacco amblyopia, think their view is strongly supported by the fact that among the army of smokers there are relatively a few only whose sight becomes effected. The asserted absence of amblyopia in Constantinople, where smoking is so general, seems at first sight to support more strongly still the above view. But the *quality* of the tobacco and the *mode* of smoking in Turkey differ so much from the "shag" of England and the method of smoking in England and America as possibly to account for the Turks escaping. Sir Henry Thompson tells us the ladies of Constantinople smoke fifty cigarettes a day, merely taking a few whiffs from each, then throw the cigarette away, and he considers little harm ensues from such smoking.

If the Turk's general organism makes a rule of not suffering from tobacco, we can readily believe the eye will not claim an exception. Observers agree there are symptoms which characterize tobacco amblyopia, viz.: Central color scotoma, as well as dimination of direct visual acuity, while peripheal vision is relatively good. Idiosyncrasy of constitution, mental depression, or bodily infirmity, may possibly account for the elective affinity of tobacco, alcohol and other poisons for certain individuals. But to deny that tobacco produces amblyopia because so large a number smoke their poison with impunity, is as unreasonable as to deny small-pox can reproduce itself because the majority escape: or the general belief that cirrhosis of the liver is caused by alcohol because so many dram drinkers maintain sound livers, or that cold and wet can produce rheumatism because so few of the exposed multitude suffer.

Dr. D. W. Cathell, the author of the popular book entitled "The Physician Himself," announces that the third edition of this work has been exhausted and that the fourth edition greatly enlarged and improved, is now in press. This book has had an enormous sale, which testifies to its value to the profession.

Correspondence.

Editors Maryland Medical Journal:

Dear Sirs.—I cannot say that I desire any controversy with you, especially since it is apparent that you are not willing to do me justice, and since your opinions appear to be already made up.

I have said plainly that in my "Open Letter" I was not making war upon Baltimore or her schools, and that I meant no unkind reflections upon her citizens or physicians, and the most obtuse Englishman can readily understand that if I had meant a graduate of your University I would have said simply full-fledged (that is full-fledged in the estimation of everyone, and so declared by the Faculty of the school) and not what I did say, "full-fledged in his own estimation."

And I have declared that I did not mean to reflect upon the honor of Prof. Tiffany either as a gentleman or as a physician, but I did mean to convey the idea that it is a grave mistake for him, or any other teacher of medicine, to say that preparatory study is unnecessary before attending medical lectures, because I do honestly believe that a medical student in a lecture-room, with no preparation, is as much at a loss as the mariner is at sea without rudder and compass. I meant this also, that when a man seeking information is informed that preparatory study is not necessary he should be assured at the same time that if he chooses to pursue such a course it will require a long time, close application, and a very considerable outlay of money in order to be fitted for the duties of a physician.

He should not be left in his ignorance to suppose that "doctors are born, not made;" and, born after a very short gestation.

I was for six years a member of our Board of Examiners, and can testify to the general good standing of the graduates of your University, and I can assure you I meant no reflections upon them in my "Open Letter" or upon any regular-bred physician.

I was not thinking of a war with true physicians, *but with quacks et omne id genus*, and in the fight if I lay too much stress upon a sin of omission (rather than commission) I beg you to excuse me.

I am very respectfully yours,

R. L. Payne, M. D.

Society Reports.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD FEBRUARY 9TH, 1885.

(*Specially Reported for the Md. Med. Journ.*).

The Association was called to order at 8.45 P. M. by the President, Dr. J. T. Smith, Dr. G. Henry Chabot, Secretary.

On the report of the Committee of Honor *Dr. Jas. A. Steuart* was unanimously expelled from the Association for recommending a proprietary medicine.

SPECIMEN OF ULCERATED VERMIFORM APPENDIX, SUPPOSED CAUSE TUBERCULOSIS.

Dr. Chambers related the following case and exhibited specimens of same. He said he had no clinical history of this case. The patient was a man about 30 years of age. Died of peritonitis caused by inflammation of the veriform appendix. On post-mortem examination, tubercular deposits were found in the lungs, large and small intestines. Is the interesting because it occurs so seldom in the veriform appendix. Dr.C. could not find a foreign body to cause inflammation.

Dr. Biedler asked how much the lungs were involved.

Dr. Chambers said he had adhesions in lungs. Had no clinical history at all. Did not know how long lungs had been involved.

MISCARRIAGE.

The discussion of the appointed subject was opened by *Dr. P. C. Williams.* He said abortion is the expulsion of the ovum prior to the first six months, after that it is called premature labor. Abortion is divided into spontaneous, accidental or criminal. Criminal abortion is the most dangerous. In dysmenorrhœa we usually have pain first and discharge afterwards, while in abortion we have the discharge first and pain after. Abortions are most dangerous about the third or fourth month. Treatment: If there is much hemorrhage we should tampon the vagina; this guards against further loss of blood. Wait from twelve to twenty-four hours; then remove the tampon and examine os. If it is not dilated and we still have hemorrhage, tampon again. We ought not do any difficult operation unless necessary.

Dr. Erich agrees with Dr. Williams. Was surprised that Dr. W. did not mention

giving small doses of ergot in these cases, as he had learned this from Dr. Williams. Give, say ten drops from time to time until hemorrhage is arrested and the fœtus retained. Mentioned a case in which he had used this treatment with success. In reference to the tampon, would only use after the ergot had failed. He does not look upon the tampon as an innocent thing. Thinks you keep the decomposing blood shut up in the vagina. Has seen a case of tetanus result from this. If the hemorrhage keeps up you had best remove the placenta with the dull curette. You cannot do any harm with this.

Dr. Rohe said in retro-flexion, where the uterus are bound down, we will often have abortion. Mentioned a patient in which this was the case.

Dr. Jones thinks the cord will often cause abortion by being twisted around the limbs of the fœtus. Placental apoplexy is a kind of inflammation of the placenta. He prefers to give opium, in starch, by the rectum, in these cases. Obstinate constipation, spinal irritation and mental anxiety may cause abortion in young women.

Dr. Waters asked if Dr. Erich ever saturated the tampon in glycerine to prevent septicæmia.

Dr. Erich said he never had much experience with the tampon; uses an elastic tampon inflated with air or water. Places ergot before the tampon.

Dr. Scarff thinks the tampon should be placed before ergot. Has used it very often without any bad affect. Saturates the tampon in a solution of boracic acid.

Dr. Chambers thinks the ergot will set up contraction; this is what we want to prevent by giving opium.

Dr. Erich said the ergot will stop the hemorrhage. After the expulsion pains come, then the ergot will do harm.

Dr. Biedler said it was a question whether the tampon could set up irritation enough to cause tetanus. He is in favor of the tampon; has never seen any bad result from it.

Dr. Williams said he did not think the septic influence of the tampon amounted to much. An ordinary bandage saturated in vinegar, solution of carbolic acid or boracic acid makes a very good tampon. Does not think we lose anything by letting the fœtus remain as long as there is no putrefaction.

The discussion was then closed.

On motion, the Association adjourned.

PROCEEDINGS OF THE MEDICAL SOCIETY, DISTRICT OF COLUMBIA.

STATED MEETING HELD DECEMBER 10, 1884.

(*Specially Reported for the Maryland Medical Journal.*)

The Society met with the President, Dr. Garnett, in the chair, Dr. W. H. Taylor, Secretary.

Dr. Lamb presented some very beautiful

SPECIMENS OF THE TYPICAL LESIONS OF TYPHOID FEVER,

and gave the following histories of the cases:

Case 1321. Soldier; sick for six days, walking around. Seventh day, temperature rose to 105.2°; no gurgling; no tympanites; slight diarrhœa; hebetude, passing in a few hours into active delirium. Died eighth day. Autopsy: Peyer's patchers thickened. Louisiana.

Case 1419. Soldier; during a long and hard march through mountains of Wyoming complained for three weeks mainly of pain in back of head and neck; had fever daily; no chill; no spots; no diarrhœa, but abdomen tender. At end of fourth week appeared to be convalescing, when perforation took place, and he died two days later. Autopsy: Peyer's patches slightly thickened; two perforations; peritonitis; spleen enlarged. Wyoming.

Case 1471. Soldier; had tertian intermittent fever while on scout. When brought to hospital, symptom of intermittent fever, continuing for about four weeks; temperature normal in morning, above 100° in evening; bowels constipated; no gurgling; no tenderness. Suddenly a large hemorrhage from bowel took place, recurring at intervals for three days, then death. Autopsy: Peyer's patches ulcerated, many of them presenting sloughs; spleen enlarged. Texas.

Case 1509. Soldier; previous history not known; sick in hospital twelve days; no fever; no quickened pulse; no tympanites; no pain until two days before death. At no time was tongue found red or dry; had diarrhœa only one day. Was conscious until a few minutes before death. Autopsy: Peyer's patches ulcerated. Montana.

Case 1703. Soldier; sick for a few days with what appeared to be remittent fever; cerebral embolism left side with right, hemiplegia then occurred, and he died eight days after. Highest temperature 102.3° till day before death; no tympanites, gurgling, nor rose spots; no diarrhœa. Autopsy: the embolism mentioned; Peyer's patches thickened; spleen enlarged. Nebraska.

Case 1659. Girl; aged 15; died of typhoid fever. No epistaxis; no nausea; no anorexia; no tympanites; no iliac tenderness; no hebetude; some diarrhœa for two days; went to school seven days before death. Autopsy: sloughing ulcers of Peyer's patches. Washington.

Case 1662. Girl; aged 15; died of typhoid fever. Temperature reached 105°, pulse 140; delirium most of the time; *no diarrhœa.* Autopsy: Peyer's patches and solitary glands enlarged, softened, some of them showing incipient ulceration; spleen enlarged. Washington.

Case 1612. Typical case of typhoid fever. Washington.

Case 1104. Soldier; aged 23; had chills and fever for about ten days. No diarrhœa; no tympanites; no gurgling; no eruption. The only symptoms of typhoid fever were hot skin, dry tongue, delirium and mental vacuity. Autopsy: Peyer's patches thickened and presented incipient ulceration. New York Harbor.

DISCUSSION.

The discussion on "Mild Cases of Typhoid Fever" was continued by *Dr. W. G. Palmer*, who said he fully concurred in the statements of Dr. W. W. Johnston, and it would be merely multiplying words to add anything further.

Dr. King, although not specially interested in the subject of typhoid fever, has listened with a great deal of attention to the present discussion. He thought Dr. Johnston was speaking of two separate fevers, and Dr. Mackall of still another.

Dr. King sometime ago entered into a thorough study of malaria. In doing so he had been struck by the fact that nearly every author says that typhoid fever has come in time to take the place of the malarial fevers which have disappeared on account of better drainage or other reasons. Dr. King could not help agreeing with Dr. Johnston, and he thought the specimens presented here to-night by Dr. Lamb were corroborative of Dr. Johnston's opinion. Malaria is too often a shield for the Doctor's ignorance of the true cause of trouble, just as the liver was fifty years ago. In spite of all the discussions which have taken place about malaria, and although it is constantly on our tongues, no one knows what it is. It cannot be demonstrated to be a vapor or the product of a marsh, for it is found on mountain tops where marshes never existed.

Dr. Schaeffer contended that the cause of malaria had been described, but as the discoverer was not a German not much attention had been paid to the matter. He referred to the palmella fungus, which had been cultivated by Dr. Salisbury and had caused malarial fever in a young man who slept in a room where the germs were exposed in a saucer.

Dr. King had heretofore thought that no reliance was placed upon the assertions of the Ohio doctor. Krebs and Crudelli have found, they say, a bacillus in the Pontine marshes different from the Ohio fungus, and yet we are still at a loss as to the cause of malaria. In reply to a question by Dr. Taylor, Dr. King said he did not know the name of the bacillus causing typhoid fever.

Dr. Taylor could not altogether agree with Dr. Johnston in one or two particulars. In the first place, it did not appear very clear that typhoid fever was due to a specific poison; in the second place, Dr. Taylor did not think it well to be too hasty in pronouncing a case of fever typhoid; in the third place, he could not see such great objection to the term typho-malarial, unless it could be proved that typhoid poison and malarial poison could not be present in one individual at the same time. It was difficult at times to class a case of fever, and some of the most experienced men could not agree even after a post-mortem examination.

Dr. Fry deemed it a settled fact that some fever of obscure origin prevailed at times in this city. Dr. Johnston thinks it is typhoid fever. Dr. Mackall calls it mucus fever. He himself had never seen a patient die from malarial fever. Month after month, however, many deaths are reported from such a cause. Before speaking of the differential diagnosis, he would say that he thought it a better plan to first put your patient in bed and order a liquid

diet, and then strive to make a diagnosis rather than reverse this order of things. He did not think it wise to let the patient go about and eat as he pleased, whilst the doctor was ascertaining the nature of the fever. Digestion and exercise increase fever heat. Once the patient is safely in bed, the doctor can set about excluding diseases of the air-passages, which can be done by local examinations. A symptomatic examination he thought would enable the attendant to exclude gastro-intestinal disease. Dr. Mackall says that mucus fever is peculiar to early life. Now, Murchisen says that, during ten years of practice in the London Free Hospital, fifty per cent. of the patients suffering from typhoid fever, were between the ages of fifteen and twenty-five years. As to typhoid attacking the robust and mucus fever the weak—it is a well-known fact that a debilitated state of health renders a person a fit subject for typhoid fever. Dr. Mackall also states that ulceration of Peyer's patches may occur by the downward passage of the disease in severe cases of mucus fever. On the contrary, we know that this state of things occurs in the mildest cases of typhoid. He believed typhoid to be a specific fever, caused by a specific germ.

In the cases we meet here, it is often difficult, at first, to tell whether the patient is suffering from a mild typhoid or a remittent malarial fever. Dr. Fry's habit was, he said, to produce cinchonism the first day, and if the result did not prove the case malarial, he treated it as typhoid. He then gave the patient ipecac and calomel, and he expected a sub-normal temperature to follow for ten days or two weeks, and that the patient would lose considerable flesh. He never gave these drugs after the first four or five days. There was nothing new in this use of calomel.

Dr. Mackall wished to correct one or two mistakes of Dr. Fry. As a rule typhoid fever occurs from the age of 15 to 35, and these were the figures Dr. Mackall had used, following in this matter Liebermeister. If Dr. Fry believes in a specific poison causing a typhoid fever (specific disease), how does he account for his wonderful results with calomel and ipecac? The beneficial effect of such drugs would rather indicate the gastro-intestinal character of the disease.

Dr. Johnston, in closing the debate, said he had little or nothing to add to the remarks originally made by him. He had thought that there must be many physicians in Washington who believed in a fatal malarial fever. If such were the case, none of them, except Dr. Taylor have given any evidence of such a belief. Dr. Lamb has furnished the most striking evidence in favor of the speaker's opinion. The specimens he has brought to our notice present all the characteristic lesions of typhoid, and yet the histories of the cases present none or few of the characteristic symptoms of the disease. In the speaker's opinion every case of idiopathic fever should be treated as typhod. If such a method would be followed, the malarial mortality would be very sensibly reduced. The argument furnished from pathological anatomy, he considered unanswerable. In the non-fatal cases we are compelled to make our diagnosis from the clinical history. How often do we hear a parent say that a child has fever every day, but none in the morning, and yet, if the temperature were taken in the morning, it would be found above normal. Typhoid fever is a disease of more or less definite duration, running from 18 to 20 days, or thereabouts. You can predict almost with certainty, when the fever will subside, unless complications or accidents occur. Then another argument: these very mild cases will die during convalescence, from lesions of typhoid fever. It is possible for a patient suffering from mucus fever, to die from such lesions at such a stage of the disease. Another very strong argument is the fact, that in these mild cases of typhoid fever, the patients have a very tedious convalescence, and suffer from a debility seemingly out of all proportion to the symptoms. They become much more anæmic than from any disease of a different nature and of a similar duration. He thought this was a matter of great importance, and he hoped to see in the future a change in the reports of the Board of Health. More exact information would be obtained in regard to these fevers, from a closer study of facts.

Dr. Muncaster said most of the fevers that he saw commenced as remittent or intermittent. The patient gradually became weaker and the typho-malarial type was developed. He thought there must be some mistake as to our not having cases of death from malarial or remittent fevers.

The cases he saw would commence by a chill. The patient would have a furred tongue and suffer from great depression. As to the disappearance of malaria in a certain place and the subsequent prevalence of typhoid fever, he thought this was rather due to the fact that the malaria had been relieved than that typhoid fever had taken its place.

Dr. Schaeffer considered Dr. Johnston's point well taken, but he supposed that gentleman would scarcely deny that congestive fevers kill. These, however, could only account for three or four cases a month, leaving a large number of other deaths unaccounted for.

Dr. Lamb said some of the specimens he had presented were from cases considered malarial before the autopsies.

Dr. Mackall asked Dr. Lamb if there were any specimens of Chickahominy fever in the Museum or cases of Asiatic cholera dying with all the characteric symptoms of typhoid fever.

Dr. Lamb said there was an abundance of specimens of the so-called Chickahominy. In Asiatic cholera there was faint thickening of Peyer's patches and enlargement of the solitary glands.

Dr. Lamb said, in reply to a question by Dr. Johnston, that mountain fever was a term applied by different surgeons to different diseases. Many of the specimens furnished the Museum were indicative of typhoid fever.

Dr. Johnston said that a few years ago mountain fever was considered malarial, and all sorts of theories were invented to account for the presence of malaria in the mountains. Dr. Smart advanced the opinion that in certain instances it came from drinking water which had its origin miles away.

Dr. Mackall said Liebermeister stated that in autopsies performed on five hundred people who died from eating putrid food, the lesions were identical with those of typhoid fever, although no typhoid fever germs could be traced.

On motion, further discussion was postponed one week, and the Society adjourned.

STATED MEETING HELD DEC. 17, 1884.

Dr. C. E. Hagner presented a specimen of a curious cyst tumor removed from the inner and upper part of the thigh of a lady patient of his.

On motion of Dr. Taylor, the specimen was referred to the committee of microscopy.

The unfinished debate on "Typhoid Fever" being resumed:

Dr. Garnett stated that he did not agree with Dr. Johnston in some particulars; he thought that he had not drawn a distinction as he should have done between the contagious typhoid fever, which was propagated by contagion, and gastro-enteric fever which was not contagious, and he thought Dr. Lamb had drawn erroneous conclusions from the specimens presented by him to-night, when he made the statement that typhoid fever might supervene upon various diseases and leave the lesions post-mortem, of true typhoid fever. There was no doubt that a typoid condition in various diseases might leave lesions somewhat like typhoid fever, but these could very readily be distinguished from the lesions of a typical case of contagious typhoid fever produced by a specific virus. As to malarial fever he did not believe it was due to a poison contained in gaseous emanations from decomposing vegetable matter, but that the poison which caused the different forms of fevers, called malarial fever, was produced by atmospheric variations. He would like at some future time to take up and discuss these very interesting subjects of typhoid and malarial fevers, and express his views on the subject fully to the Society, but he was not able to do so to-night owing to a very painful catarrhal affection of the larynx, which rendered it exceedingly painful for him to talk.

On motion of Dr. Palmer, the discussion on Typhoid fever was closed.

DISCUSSION OF THE LESIONS OF TYPHOID FEVER.

Dr. Lamb said, Mr. President: At the last meeting the question was raised as to whether the so-called primary lesions of typhoid fever are *characteristic* or not. Two other questions were asked: first, in regard to the intestinal lesions in Asiatic cholera; the second, as to those found in the Chickahominy fever. I have brought the following specimens here to help answer the questions. The first is from a case of pneumonia following measles. At the autopsy some of the Peyer's patches showed slight enlargement of some of the individual follicles. The patch in the

specimen is four inches long; is from near the ileocæcal valve, and a carmine injection having been thrown in the vessels, the details of the patch are well brought out. Here apparently is the typhoid process of only a few days duration supervening in a patient sick with pneumonia after measles.

The second specimen is from what was called in its time "Chickahominy fever," from a soldier brought from City Point to Philadelphia in August, 1862, who was sick in hospital twelve days, and his diagnosis—typhus fever. At the autopsy the ileum was reddened in patches; solitary glands enlarged and reddened; some of the Peyer's patches slightly thickened, others normal, none ulcerated; color showing slaty discoloration, several ecchymoses, and in descending colon a few small stellate dark ulcers (possibly cicatrizing ulcers of old diarrhœa). Dr. Woodward would have classed this case as a *typho-malarial* fever, with a probable preponderance of the malarial element. The next case was also diagnosticated *typhus* fever. It is as nearly a typical case of typhoid during the second week as is likely to be found; Peyer's patches enlarged and thickened; solitary glands of the size of small shots. The fourth specimen is from a soldier who died from what the attending physician said was an obscure disease resembling typhoid fever. At the autopsy the lungs were found hepatized, mesenteric glands enlarged, dark pulpy thickening of Peyer's patches. This thickening is peculiar; it is quite different in its form and appearance from the ordinary lesions, and Dr. Woodward looked upon it as indicating the scorbutic complication of many of the camp fevers.

The next specimen shows cicatrization of ulcers of Peyer's patches and extensive ulceration of the colon, mainly acute in character. The soldier was brought from the field. Abdominal pain; frequent mucus stools and hebetude are recorded. He began to improve after a few days in hospital, but the diarrhœa continued. After the thirtieth day tertian fever appeared and diarrhœa still continued. He improved a second time; again relapsed and died the forty-ninth day after admission. Apparently a recovery from the fever and death from acute diarrhœa or dysentery.

The next case is from a paroled prisoner at Annapolis, in the fall of 1862. He was sick in the hospital two months and nine days. Symptoms not stated, but a diagnosis of typhoid fever. At the autopsy the ileum was thickened and presented numerous follicular ulcers, and there are two sloughing ulcers. Apparently an acute fever supervening in the course of a chronic diarrhœa, which extended to the small intestine. Unfortunately the condition of the large intestine is not mentioned.

The next specimen is different from all the previous ones. In this case the lower twenty inches of the ileum was thickened and deeply ulcerated, but the lesions are not of Peyer's patches and solitary glands; the large intestine was said to be "inflamed" throughout. The soldier was treated for "chronic diarrhœa," and died thirty-two days after admission to hospital. This is a case of extension of the diarrhœal process into the small intestine.

The next is a specimen of tubercular ulceration of Peyer's patches, which is typical. The transverse ulcer with thickened margins and uneven base, together with the tubercular lungs, and ulceration of larynx and trachea, put the case beyond the possibility of doubt.

The last specimen is from Asiatic cholera, and a faint thickening of Peyer's patches, barely recognizable, but marked prominence of the solitary follicles. From the epidemic of 1866 this specimen by itself, in the absence of history or post-mortem results, might readily be thought to be from a typhoid case of the first twenty-four to forty hours. Of course the operator at the examination could scarcely mistake, especially in view of the history, which is Asiatic cholera, is usually obtainable.

Except in rare cases, and nearly all rules have exceptions, there should be no hesitation, I think, in affirming the existence of typhoid fever where the lesions of Peyer's patches and solitary glands and spleen, which are usually described as characteristic, are found. At the last meeting I presented specimens from cases of very varying history, which yet united in showing these characteristic lesions. These cases are a part of the great multitude in which the diagnosis ranges through nearly the entire nomenclature of diseases, but in which the autopsy shows a uniform lesion, the variations being only within narrow limits. It seems reasonable to me to say that these

lesions point out the disease, whatever may have been the clinical history. The manifestation of the symptoms is an *individual* matter. A case of acute general peritonitis, one of the severest and most usually fatal diseases, may in one patient be a typical one, and in the next, the patient may walk around the room within a few hours of death, and complain of little else than discomfort. Is there anything in the nature of things to prevent a typhoid process being set up in a patient already sick with another disease, and if he die of that other disease and we find the typhoid lesions, why should we say the lesion is *not* typhoid. If typhoid be a specific disease, with a constant course and a certain time to continue, which cannot be abortive, it may be that the very fact of suffering from another disease increases in many cases the susceptibility to typhoid. If it will inevitably appear in one exposed, after a certain period of incubation, what is to hinder it doing so if a man be sick with a malarial, or diarrhœa, or some other disease. *What do we absolutely know about the possibilities?* When, therefore, we examine a body and find these particular lesions, answering to the first, second or third week of typhoid, it seems more reasonable to me to say that the typhoid process was there, whatever may have been the clinical symptoms. To throw doubt upon this fact, (I will call it fact with rare exceptions), the only satisfactory test must be the most careful clinical and post-mortem observation, and this is what is lacking. By this I do not mean to question the accuracy of observation of some who have been quoted as doubtless; Liebermeister among the number; to whom I would quote Liebermeister himself in his own words: "The lesions which we find after death from typhoid fever are so characteristic that they of themselves make known the nature of the disease even if we are ignorant of the symptoms and etiology of any particular case. This is not only true of the more severe cases, but even in very mild cases where death results from some complication. An experienced observer can find enough lesions to make the anatomical diagnosis. * * * The most prominent symptoms of typhoid fever are not due to the intestinal and mesenteric lesions, but the general disease. * * There is no necessary proportion between the intensity or extent of the intestinal lesions and the intensity of the general symptoms. * * * * These lesions are present in all cases without exception, developed or undeveloped." He describes these characteristic lesions, and uses the strong language quoted, showing his own abiding faith in their constant relation to the fever. *And here is the important point that the lesion described is the constant quantity while the symptoms are the ever varying one.*

I may be pardoned for saying that I have a personal interest in this matter, having suffered with camp fever in the spring of 1862. In this case, fortunately or unfortunately, a post-mortem examination was not possible, but I can scarcely doubt that the Peyer's patches did show, if they do not now, the pigmentation.

Perhaps I ought not to touch the subject of typho-malarial fever. But to my mind, while in the words of the author of the name, it does not constitute a specific type of fever, it still seems to express a fact that causes of disease may act together at times and the product be somewhat of typhoid, and the word therefore appropriate.

CLINICAL SOCIETY OF MARYLAND

STATED MEETING HELD FEB. 20TH, 1885.

The Society was called to order by the President, Dr. B. B. Browne, at 8.40 P. M., Dr. Jos. T. Smith, Secretary.

Dr. R. B. Morison read the first paper of the evening, the subject being a

CASE OF ELEPHANTIASIS ARABUM OF THE UPPER EXTREMITY.

(See the Journal of February 21st, 1885, pg. 311).

DISCUSSION.

Dr. J. E. Michael said he had met with a case like that of Dr. Morison's: it was in a boy fourteen years of age; no cause could be assigned for the trouble, and at no time throughout its whole course was there any sign of inflammation. The boy otherwise was in good health; the bones and soft parts were enlarged; the leg, while it retained its normal sensation, was felt to be heavier than the other by the patient. The treatment consisted only in the use of the elastic bandage; the ligating of the arteries was thought of, but it was thought best not to do it as the lad suffered no great in-

convenience. As far as he had been able to find, all authors agreed in ascribing repeated attacks of inflammation as one of the marked characters of the disease, but in his case such was not observed.

Dr. E. M. Schaeffer had seen a case in September, 1884, with Dr. Robert Wilson. It was that of a girl, fifteen years old, well developed and healthy. She had had ulcers upon the lower extremities in early life, the leg then began to enlarge, with preceding erythematous attacks. The whole body, from the waist down, was enlarged The genitalia were much increased in size. She had had bandages applied without any result. Clay applications (Hewson's method) with bandaging for three weeks effected a reduction of two inches in circumference of leg. Only a few dressings could be used as patient then passed from under observation. The menses appeared for the first time during this treatment.

Dr. I. E. Atkinson said such cases are very interesting. Much depends upon whether we study them clinically or etiologically. In many cases, especially those occurring in the tropics, it is due to the presence of the filaria in the lymphatics, as Dr. Manson has shown, but this is probably only one of many causes. In one case a chronic chancroid caused the disease by causing an imprisonment of lymph; he had seen it from irritation of mucous patches, solid œdema of Bright's disease, etc. In Dr. Michael's case, though no inflammation showed itself, all the other symptoms of elephantiasis were present; it looked much like connective tisssue growth; it must be due to some influences governing the nutrition like those of simple lymphatic obstruction. He had seen a case in which the trouble might have been called localized elephantiasis, simply an enlarged growth of lymphatics with connective tissue. Etiologically we cannot, bring all the cases together, unless we look upon the cause simply as an irritant.

Dr. Robert Wilson, in the case noted by Dr. Schaeffer, punctured parts about the vulva and caused the discharge of matter. She had symptoms of menstruation at fourteen years, but no flow.

Dr. R. B. Morison, in reply to a question from Dr. Rohé, said he had not found any enlargement of the bones.

Dr. G. H. Rohé said he had seen one case of obstructed lymph channels; it occurred in a child whose fingers became so that they could not be brought together. He had also seen a woman, aged forty-five, who had an enlargement of the leg due to hypertrophy of subcutaneous fat, there was no enlargement of the bone and no erysipelas. He did not think simple enlargement should be called elephantiasis.

Dr. R. B. Morison had been taught that erysipelas was not of necessity present in all cases; he had seen cases like Dr. Michael's and they would have been called elephantiasis. He thought the parasite mentioned by Dr. Atkinson one cause. The disease must be classified according to many causes. It remains to be proved that inflammation is a necessary accompaniment of elephantiasis.

Dr. J. N. Mackenzie exhibited

TWO SPECIMENS OF SYPHILITIC DISEASE OF THE NASAL PHARYNX.

The one was taken from the body of a man who had died of syphilis. The processes of hypertrophy and atrophy of the membrane were well shown in the specimen, and on the posterior end of the inferior turbinated body was a large, stellate depressed cicatrix. There were caries of the frontal bone; the post-pharyngeal tissues were infiltrated with pus, and gummatous growths were found in the liver, spleen, etc. The specimen showed the well-marked development of fibrous tissue in the erectile bodies, which Dr. M. thinks characterizes the hypertrophic catarrh of syphilis. Dr. M. called attention to the marked patency of the nostril caused by the peculiar stellate cicatrix and said that he aimed to imitate this as far as possible, in his operation with the galvano-cautery by the stellate incision.

The next case was one in which perforation with complete destruction of the cartilaginous septum had occurred. A depressed stellate cicatrix was found on the floor of the nostril which involved the septum to a certain extent. The patient died of pneumonia, and there was no evidence of syphilis to be found on post-mortem examination. The diagnosis was made by exclusion and by the peculiar nature of the cicatrix and the perforation of the septum. In commenting on this case, Dr. Mackenzie called attention to the tendency of syphilitic ulceration to crop out in some portion of the upper respiratory tract years after the constitutional malady had apparently

run its course. In the congenital form of the disease the pharynx is the most frequent seat of isolation; in the acquired affection he had met with it in every portion of the respiratory tract, and had even found the disease isolated in the middle third of the trachea in a case he had published in the *Wiener Medicinische Jahrbuecher* several years ago. He thought this question of isolation of syphilitic lesions in the upper organs of respiration one well worthy of future study and attention.

Dr. J. H. Branham said at the post-mortem of the case noted by Dr. Mackenzie no glands were found enlarged and no sign of syphilitic trouble elsewhere, and he therefore doubted the trouble in the nose to be due to syphilis.

Dr. N.G. Keirle said a person might have but a slight manifestation of syphilis and a number of years after may come for treatment with some form of syphilitic disease. He also spoke of a case of bulging of the velum, with resulting perforation, and the difficulty it would cause in one compelled to use his voice in public.

Dr. J. N. Mackenzie said he did not think it necessary to go into the subject of the differential diagnosis. If not syphilitic it must be lupus, but as the latter was rare he did not think it could be so called. The cicatrix was not absolutely characteristic of syphilis, but might have been left after an attack of typhoid fever, but we have in this case no history of that disease.

Dr. L. E. Neale read a

REPORT OF TWO CASES OVARIOTOMY.

(See the JOURNAL March 7th, pg. 355).

DISCUSSION.

Dr. W. P. Chunn said: Both cases spoken of by Dr. Neale are interesting ones, but from different points of view. It does not frequently happen that an operator has the privilege of attending his patient in labor after ovariotomy, nor is it a frequent occurrence for a solid tumor of the ovary to be met with. The results of the first operation show that sterility does not by any means follow a unilateral ovariotomy, nor does amenorrhœa. In some cases, however, we do see amenorrhœa after such an operation as has just been described. In such a case, where only one ovary is taken out and the courses do not appear afterwards, he thinks the cessation of menstruation is due in these instances to cellulitis and peritonitis, which goes on to suppuration and disintegration of the ovarian tissue. Of course amenorrhœa is the result. He has seen these cases in ordinary practice. In regard to the second case, where the tumor is small and matters are complicated by ascites, the diagnosis is very difficult. The semblance of fluctuation is so great at times in a soft, solid tumor that the most expert may be deceived. Dr. Thomas speaks of a case where the diagnosis was made of ovarian cyst. After the abdomen was opened and the hand introduced the same opinion was still held. The tumor was then removed entire and placed upon a table and it was only after the mass had been cut in two that it was discovered to be a solid tumor. Dr. Chunn has seen but one case of sarcoma of the ovary beside the one mentioned by Dr. Neale. This woman was first operated upon some six years ago, and a large ovarian cyst removed. She recovered and returned home in good health. About a year after the operation she returned once more saying she had another tumor. She was a second time operated upon and a sarcoma of the remaining ovary taken out, with a fatal result. This tumor was thought to be malignant before the operation, as it was comparatively small and was accompanied by a large amount of ascites. The lymphatics were enlarged and the legs œdematous. The practical question to be decided is whether the tumor is a solid medullary growth free in the abdominal cavity, or whether it is a cysto-sarcoma where the malignant ulgitations are securely inclosed within the cyst wall. In the former case an operation would not be advisable. In the latter, the sooner the operation is done the better.

Dr. J. N. Mackenzie read a paper on the

CLASSIFICATION OF THE STAGES OF CHRONIC NASAL INFLAMMATION, BASED UPON THE ANATOMICAL CHANGES WHICH THE NASAL ERECTILE TISSUE UNDERGOES.

Classification of the Stages of Chronic Inflammation.

I. Simple Inflammation (rhinitis simplex) divisible into periods of

a. Irritability of the cavernous tissue.

b. Permanent dilatation of the same: Chronic coryza.

II. Hypertrophic(rhinitis hypertrophica) divisible into periods of

a. Hypertrophy with dilatation.

b. Complete hypertrophy.

III. Atrophic or cirrhotic(rhinitis atrophica or cirrhotica) divisible into periods of

a. Commencing and

b. Complete atrophy or cirrhosis.

The characteristics of the different periods were then described in detail. The first period of the simple inflammatory stage is characterized by abnormal excitability of the erectile tissue finding its expression in sudden stoppage of one or both nostrils under a multitude of conditions; the second period is characterized by a permanent puffiness of the erectile tissue to be distinguished from true hypertrophy—a condition which forms the connecting link between simple inflammation and true hypertrophy. The first period of the atrophic stage is characterized by pronounced contraction of the tissue, leading to an uneven, nodular condition of the turbinated bodies, whilst the second period represents complete disappearance of the erectile bodies and their conversion into a cirrhotic tissue.

After giving some suggestions as to the early recognition of chronic inflammation from the behavior of the erectile bodies, and calling attention to certain anatomical guides in measuring the amount of hypertrophy and atrophy, Dr. Mackenzie next proceeded to lay down the general principles which govern the rational treatment of the different stages. In the earlier part of the first stage, the treatment is mainly hygienic (attention to skin, general health, protection against external irritation, removal if possible to an equable temperature, etc.), and consists in the removal of the cause (local irritation, systemic diseases or vices of constitution, surroundings, reflected irritation, etc., etc.). Local treatment is often unnecessary, in many cases harmful, and should be confined to the judicious use of medicines in solution or in vaseline, cosmoline, etc., and in remedies to reduce reflex excitability. Medicines in solid form contraindicated.

In the second period, the same as above plus remedies to stimulate the contractile power of the subparalytic fibres of the intercellular walls (strychnia occasionally useful). In this period, if the above fail, the galvano-cautery or electrolysis may be resorted to. The treatment of the hypertrophic stage is essentially surgical, that of the atrophic hygienic and tonic; the local measures consist in securing thorough cleanliness and lubrication of the nasal passages.

SPECIMEN OF EPITHELIOMA OF THE HIP.

Dr. J. E. Michael related the following case and exhibited specimens of the parts removed; the patient was a man aged 50. Five years ago he had a sore upon his lower hip. When he first came into the hospital it was thought not much was required to be done, but upon careful examination it was found that the under lip and chin were involved in the disease as far back as the Masseter muscle; found no disease of the glands. The case was one of epithelioma of lip. The lip and lower jaw were removed sufficiently to get rid of all the diseased tissues. The hemorrhage during the operation was profuse, the artery in the bone bled very freely, and its canal required to be plugged with wood. That the tongue might not be drawn into the throat its tip was pierced and a wire put through so that it could be held out during operation. It thought the bone was involved, but examination after removal showed this not to be the case. The diseased tissue, however, had involved the periosteum and the bone would soon have suffered.

ANOTHER BACILLUS OF SYPHILIS.—Dr. Lustgarten, assistant in the Skin Clinic at Vienna, has discovered what he claims to be the bacillus of syphilis. It resembles, to some extent, the bacillus of tuberculosis, but differs from it in that it is always found within the cells. Koch examined the specimens and found that they differed morphologically from the bacteria of tuberculosis. Experiments in cultivation and inoculation must first be made before much credence will be given to the discovery. It would be interesting to enumerate the various bacteria of syphilis which have appeared and vanished from the field of pathological research.

The Rush Medical College of Chicago recently graduated a class of one hundred and fifty-one members.

Editorial.

PROF. MARTIN AND THE ANTI-VIVISECTIONISTS.—This eminent physiologist who has done so much to advance the study and knowledge of normal and even of morbid animal processes, and of whom we may well feel proud that he belongs to this community, has lately been the object of many attacks in the local press, direct and indirect, and has not escaped the animadversions of even his own colleagues of the Johns Hopkins University Faculty. No doubt the motive of these various articles is to be found in a criticism of Prof. Martin's methods, which appeared in a recent number of a journal published monthly in England, and called the *Zoophilist*. This journal is the organ of a society which embraces among its officers men of high rank and scientific attainments. Prof. M. has felt impelled to notice this attack, which he does in a pamphlet of nine pages now before us. He takes the ground, very properly we think, that such charges are not to be ignored, that they are not only slanders upon those who are occupied in the most important investigations in which the human intellect can be engaged—"the discovery of the phenomena of life, the conditions of health, and the methods of preventing and curing disease in man and the lower animals"—but that they tend to lead astray the public, and even deceive persons of eminence and influence who are unacquainted with the objects and methods of physiological science. The people of Baltimore, especially he says, have a right to know whether he is teaching their sons wantonly to inflict pain. The publication of the truth is not to be feared, but such misrepresentations as are contained in the *Zoophilist*, and Prof. M. urges those who wish to learn the truth in regard to the experimental practices in question, to visit his laboratory and see for themselves.

The paper of Prof. Martin, which afforded the occasion of the misrepresentation, was the one entitled: "The direct influence of gradual variations of temperature upon the rate of beat of the dog's heart," which was published in full in the transactions of the Royal Society of England, and was honored by being selected by that Society as the "Croonian Lecture" for 1883. This paper undertook to settle the question of the cause of the rapid beat of the heart in fevers, which very often leads to a fatal result from heart failure, the organ not getting rest enough between its beats for nourishment and repair. Prof. Martin was able to show by isolating the heart and lungs of the animal experimented upon, that this symptom is due to the increased temperature of the blood circulating through the organ. The blood being cut off from all parts, except the heart and lungs, the latter alone retain their vitality; but these organs are insensitive to pain. As a further means of obviating suffering the animal was brought under the influence of an anæsthetic before being killed. "To sum up: In the whole series of experiments no animals, except two, suffered any more pain than the skin prick necessary to administer morphia hypodermically. In the two exceptional cases" (to whom curaré alone was given, as anæsthetics produce effects on the heart which might have withstood the results of the experiment) "the pain was due to small incisions through the skin of the neck and the introduction of a tracheotomy tube. Within four minutes this pain was nearly (probably completely) abolished by tying the main arteries of the brain, and within another four minutes was made impossible by the tying up of the remaining two small arteries which carry blood to that organ." Prof. Martin proceeds to place side by side the statements of the critic and the truth, characterizing in uncompromising English the former and amply justifying his charge of misrepresentation. Let us hope that Prof. Martin's sturdy defense may bring conviction to the minds of those who may have been led astray by anti-vivisection heresies, and may neutralize the efforts of those who are endeavoring to place us in the position of the medical profession of England who are debarred by law from researches of this character.

ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.—It is a circumstance to be regretted that the annual meeting this year of our State Society, will fall upon the same day—the 28th inst.—as that of the American Medical Association; regretable because those who will go to New Orleans would like to be present during the sessions of our Maryland Society, and also because the latter will thus be deprived of the presence and

participation of many who doubtless will be greatly missed. If it can be so arranged we hope that steps will be taken to change the date of our own meeting, making it come, say about May 12, so as to give the delegates to New Orleans ample time to return and prepare for it. The Executive Committee—as we understand—has declared its inability to do anything in this direction, as the constitution prescribes unalterably the date of the meeting; we would therefore suggest that the President be requested to call a special meeting in order that the date may be postponed. This can be done by the President in his discretion.

We would also embrace the opportunity to urge all who are connected with the Faculty, or even interested in its work, to be present at the meeting. The Chairmen of committees and sections should be prepared to present their reports, and those members who have met with rare or curious cases, or who have made valuable original investigations or observations during the year, should record them for the benefit of the profession. We must not forget the prestige of our ancient society, the value which has everywhere of late been accorded to our transactions, or the fact that our doings are heralded each year to all parts of the civilized world. Surely there is no occasion then to appeal to our State pride to make us bestir ourselves for the coming meeting.

The meeting will probably be a very important one. Besides ethical matters, which imperatively demand consideration and action at this time, other questions of the greatest interest will probably be brought up—as State Medical Legislation, a Medical Insurance and Beneficial Society, etc.

One other matter we would impress upon our brother practitioners of the city—the duty of hospitality to our country brethren. Nothing would prove a greater attraction to them, or serve so well to solve the difficult problem of how to get them in large numbers into our Society, than a cordial reception and entertainment during their short stay among us. Can we not arrange to give them a supper? The editors of this Journal will be glad to receive subscriptions for this purpose and acknowledge them in our next issue.

Tyndall on Living Contagia.—Prof. Tyndall has been one of the foremost and most ardent advocates of the germ origin of disease since the genius of Pasteur placed the theory upon a scientific basis. His penetrating eye quickly peirced the veil of futurity and foresaw the importance of the principle, and he has not hesitated on every possible occasion to impress upon the profession and the public its transcendent interest. His last utterance was in a lecture before the Royal Institution, Jan. 16. The study of fermentation, he said, was the first step in the chain of discoveries which preceded our present knowledge of the subject. This was proven to be due to the presence of living organisms which decomposed the material undergoing fermentation. Thus from the sugar of the grape came alcohol, and from milk lactic acid. There was a natural transition from this to a consideration of the maladies of wine and beer, with the result of securing much greater perfection and certainty in the processes of manufacture of these articles, a simple microscopic examination sufficing to put the manufacturer right. The practical application of these discoveries to human ailments was made by the great Lister, whose genius traced the analogy between processes of fermentation and disease, and saw the resemblance of the former to the growth of living things. The exclusion and destruction of the disease organisms appeared to his keen vision the great object to be desired, no less important to surgeons than skill in operating. The lecturer remembered when the germ theory of infectious diseases was looked down upon as an absurdity, now there was hardly a scientific physician in Europe who did not accept this theory. The share taken by Koch and Pasteur in investigating the bacillus of wool-sorter's disease or splenic fever, one of the most deadly organisms that ever invaded the system of man or brute. The lecturer closed with a warm defense of experimental vivisection.

Medical Status of English in the Soudan.—A medical correspondent, writing from the English headquarters in the Soudan, sums up the medical status of affairs there as follows: The hospitals are well supplied, the sick are well cared for, the most captious critic can find no fault; the medical staff corps are working like

men; and whether at professional duty or hauling a boat, or in desert marching, in mending a hospital-bed, or in building a hospital-kitchen, from morning to night, all day and every day, we are all hard at work, all honestly striving to help on the expedition.

Can we wonder at the achievements of the English when animated by such a spirit?

Books and Pamphlets Received.

Proceedings of the Philadelphia County Medical Society. Vol. VI. Containing the Report of the Transactions from Sept., 1883, to June, 1884. Edited by Publication Committee. Philadelphia. 1884.

Typhoid Fever and Low Water in Wells. By Henry B. Baker, M.D., Lansing, Mich. Mich. State Board of Health. 1884.

Cocaine in Ophthalmic Surgery. By P. D. Keyser, A.M., M.D., Surgeon to Wills' Eye Hospital, Philadelphia, etc.

The Physiological Effects and Therapeutical Uses of Hydrastis. By Roberts Bartholow, A.M., M.D., LL.D. Philadelphia: J. N. & C. G. Lloyd. Cincinnati, Ohio. 1885.

Experimental Researches on Cicatrization in Blood Vessels after Ligature. By N. Senn, M.D., of Milwaukee, Wis. Philadelphia: Collins Brothers. 1885.

Protection of Michigan against Cholera. Statement of the Status of the Public Health Work in Michigan. By H. B. Baker, M.D., Secretary State Board of Health.

The Baltimore University of Medicine, which was organized mainly through the influence of the late Dr. Harvey L. Byrd, held its first commencement at Ford's Opera House, on the 3rd inst., in the presence of a large audience. Diplomas were conferred on six graduates, and an address was delivered by Rev. W. H. McAllister, of Betheny Independent Methodist Church, on "Hard Work."

Miscellany.

Perforation of the Bowel from Bimanual Examination of the Uterus.—Dr. E. Schartz, of Halle, relates (*Centralbl. für Gyn.*, Glasgow *Med. Jour.*) an interesting case of where, in a woman 46 years of age, he made a bimanual examination of a uterus containing a fibroid tumor as large as a child's head. For some years he had kept down menorrhagia by the use of the curette and astringent injections, but ascites appeared, and the patient became cachectic. Fearing malignant degeneration, he determined to examine the interior of the uterus after dilatation of the cervix by a laminaria tent. Before inserting the tent, a one in a thousand watery solution of corrosive sublimate was injected into the uterus. Immediately thereafter the patient became sick, and was taken to bed without anything further being done. An hour afterwards she had a severe rigor, and the pulse rose to 140. There was severe retching and diarrhœa, with the passage of 18 ounces of blood from the rectum. The abdomen became greatly swollen, and death occurred from collapse in 40 hours. The diagnosis made during life was that of poisoning from corrosive sublimate, due to the solution finding its way into the peritoneal cavity through some diseased part of the uterine wall. At the autopsy the uterus was found intact. Pus, blood and fæcal matters were found in the abdominal cavity, and also a pea-sized perforation of the bowel a little above the ilio-cæcal valve. Many old adhesions existed, and a fragment on the posterior wall of the uterus was observed to correspond to the perforation in the bowel. One of the kidneys was examined for mercury, but none was found in it. It thus appeared that death had resulted from the tearing of the adhesion binding the posterior wall of the fundus to the bowel lying behind, and this most probably happened (when the fundus was drawn forwards) during the bimanual examination, made immediately before the injection of the corrosive sublimate solution.—*Jour. of Amer. Med. Asso.*

Treatment of Scalp Wounds.—A correspondent has drawn our attention to the treatment of scalp wounds, and in his letter he advocates the employment of the natural hair sutures. He of course refers to the

prejudice against the more generally employed sutures as tending to favor the occurrence of erysipelas, inflammation, or suppuration. This prejudice, like most others, has a certain foundation in fact. The scalp is remarkable for the looseness with which it is attached to the subjacent bone, and in simple cuts through the scalp blood and serum can readily force a way between the scalp and the bone, and the accumulation induce suppuration. Still more frequently the scalp is torn away from the skull in a longer or shorter flap, and then, if the edges of the wound are united, the serum effused from the under-surface of the detached flap is confined beneath it and suppuration occurs. If this fact be neglected, suturing scalp wounds is a dangerous step; but if it be recognized and acted upon, the sutures are altogether devoid of danger. The main thing in the treatment of any flap scalp wound, however slight the flap may be, is to secure primary adhesion of the flap to the subjacent pericranium and completely prevent accumulation of serum beneath it. This must be secured by properly adjusted pressure; and, in view of this primary indication, but secondary importance should be attached to the rapid healing of the edges of the wound. If a good bunch of hair be taken up on each side of the wound, and twisted, and then used as a suture, it is obvious that the whole surface of the scalp from which the hair springs is held compressed against the subjacent skull, and hence this form of suture skilfully employed really fulfils the indications of treatment very well. It is an error to suppose that the tissue of the scalp is more intolerant of the presence of a suture than the skin of any other part of the body.—*Lancet.*

Ingrown Toe-Nail.—Dr. Monod, in the *Union Med.*, contends that in cases of ingrown toe-nail, to effect a radical cure, the removal of the nail may be avoided by thorough cauterization of the ulcerating or granulating place with nitrate of silver. He says that one single cauterization will suffice, though correctly-fitting shoes will always form the main element in the prevention of the recurrence of the trouble.

We have several times drawn the attention of our readers to a method of treating this complaint, which is not only far milder, but also just as sure in removing the difficulty. The simple procedure, for the reliability of which we can vouch on account of a great personal experience with it, is as follows:

The sore in ingrown toe-nail is caused by the pressure exerted by the shoe on the *middle* of the diseased nail. Anybody by looking at the nail of the large toe (the one generally affected), can convince himself that the middle of the nail is higher, more prominent than the sides. But in ingrown nails it is not only that, but also much thicker. By using the least pressure with a finger on this centre, one can at once see how the irritation, and as its consequence the ulceration, are produced.

The most rational way of treating the difficulty consists, therefore, in the scraping off of this very centre of the nail. This is best done by means of a piece of broken glass, and the scraping should be continued until the operator nearly reaches the flesh. There is one symptom which at once indicates that enough has been removed, viz., pain. Until within a line or so of the flesh there is not experienced the least sensation by the person undergoing the operation, and the moment the procedure causes a sore feeling, it should at once be stopped. The same shoe can then be worn; within a day or two all pain will cease, and shortly after the ulceration be healed; for there is no longer any pressure exerted upon the centre of the nail, driving the edges into the flesh and causing the soreness. When the nail has grown sufficiently to be cut, it will be observed that for a certain distance the nail has split in the centre. Whenever the nail has grown so far as to be of the same thickness in the centre as before, the operation of scraping has to be renewed. By doing it in time, all future trouble may be avoided. Once every three months is about the usual time. The method has not failed in a single case in which we have tried it.—*Med. and Surg. Reporter.*

Electrolytic Treatment of Strictures.—Dr. Robert Newman gives the following rules for the treatment of urethral strictures by electrolysis. Use the faradic current only for spasmodic strictures, the galvanic current for organic. Six to ten Bunsen cells gives a sufficiently strong current. A bougie electrode should be selected three

numbers (French) larger than the stricture; this should not be lubricated with any non-conducting substance. The bougie is to be attached to the negative pole of the battery and a sponge electrode to the positive. The sponge being applied to any part of the body, the bougie is to be introduced and held tight against the stricture. The current is then passed, and increased slowly till the patient experiences a warm sensation. In general, the bougie soon passes through the stricture. The current should be reduced cell by cell to zero before the withdrawal of the bougie. The sitting may last from five to twenty minutes. Only one bougie should be used at each sitting.

Dr. Newman has tabulated one hundred cases where he has used the electrolytic treatment. He excludes all cases that have been under observation less than three years. Most of these he has re-examined himself or has had reports of them from other physicians, and in nearly every case the cure has been permanent. He follows no arbitary rule to determine the normal size of each urethra, but ascertains it "by the patients' feelings and by the size and force of the stream of urine."

The Thirteenth Annual Commencement of the College of Physicians and Surgeons of Baltimore was held in the Academy of Music on March 13, at 12 M. The degree of M.D. was conferred upon 155 Graduates by Prof. John S. Lynch of the Faculty. The valedictory address was delivered by Rev. John S. Foley, of this city.

The College's prizes were awarded to the following gentlemen:

1st Prize, Cathell Medal, John William Coughlin, Mass.; 2d Prize, Brown Memorial Medal, Frank C. Bressler, Pa.; 3d Prize, Howard Memorial Medal, James C. Hursh, Va.; 4th Prize, Certificate of Honor, William S. Gardner, Ohio; 5th Prize; Certificate of Honor, Amos L. Gage, Md., 6th Prize, Certificate of Honor, A. D. Marks, Ohio; 7th Prize, Certificate of Honor, Moore S. Falls, D. C.; 8th Prize, Certificate of Honor, Thos. B. Perry, B. S. C., Ga.; 9th Prize, Certificate of Honor, Walter T. McCoy, A. B., Ind.; 10th Prize, Certificate of Honor, John R. Flannigan, N. Y.; Bobbitt Prize, A. Lawson Hutto, S. C.

Prof. L. McLane Tiffany's reply to "An Open Letter" by Dr. R. L. Payne.—The following letter from the *N. C. Med. Jour.* for Feb., 1885, explains itself:

Thomas F. Wood, M.D., *Editor N. C. Medical Journal:*

Dear Sir:—My attention has to-day been called to "An Open Letter," published in the *North Carolina Medical Journal*, January, 1885, page 9, written from Lexington, N. C., dated December 26, 1884, signed R. L. Payne, M.D. On page 11 is the following:

"I will mention one more, who received a letter, which I read, from Prof. Tiffany, of Baltimore, in which the Professor wrote: 'You can come right along to the lectures, as preparatory study under a preceptor is not necessary.' Professors of medical schools should certainly be more careful, more explicit, for this man did go on (and many others do the same) without any preparation, staid three months in Baltimore, and came back a full-fledged doctor—in his own estimation. He says he was offered a position in one of the Baltimore hospitals, and declares that he 'knows as much about medicine as any man.' He is as ignorant as he is conceited, yet, having a large family connection, he is doing considerable practice.

"Now, then, I respectfully submit, that if our laws were sufficiently strict no such men as these could impose upon the people of North Carolina, even though aided and abetted by the professors of any medical school."

In the above Prof. Tiffany, of Baltimore, is charged with having aided and abetted an ignorant and conceited man to impose upon the people of North Carolina. I believe that I am the only Prof. Tiffany in Baltimore, and am connected with a medical school, therefore the above quotations from the letter over the signature R. L. Payne, M. D., refer to me, and I am charged with a grave misdemeanor and dishonorable action, not only as physician, but as a citizen. The gravamen of the charge is contained in the letter quoted in the first lines of the article above. In view of the attack made upon me I *demand* of R. L. Payne, M. D., that he publish in the next number of the *North Carolina Medical Journal* the letter upon which he founds so gross a charge, as well as the name of the man said by him (R. L. Payne,

M. D.), to have received it—for he has made use of my name—that the truth or falsity of the same may be made apparent.

The first sentence quoted by R. L. Payne, M. D., as being in my letter is a phrase that I do not remember to have ever penned—"You can come right along to the lectures." I therefore *demand* that the original (not a copy) be sent to the editor of the *North Carolina Medical Journal* for publication.

When R. L. Payne, M. D., has given authority for his attack, I will reply specifically to such statements and insinuations as refer to me—statements and insinuations which, I regret to say, do appear to be justified by the fact.

Very truly,
L. McLane Tiffany, M. D.
137 Park Avenue.
Baltimore, Md., Feb. 4, 1885.

Medical Items.

Dr. Baldwin, of Montgomery, Alabama, proposes that the names "Kollerism" and "Kollerization" be given the anæsthetic use of cocaine as a tribute to the fame of Dr. Koller, the discoverer of the local anæsthetic properties of this drug.

The general anxiety felt in regard to the condition of General Grant will not be allayed by the latest reports of his physicians. There is no longer any doubt of the fact that the General has an epithelioma of the tongue and fauces, which is gradually extending to surrounding tissues and is greatly depressing his mental and bodily condition.

Dr. Harrison Allen has presented his resignation of the Chair of Physiology in the University of Pennsylvania.

Prof. Lucae, the author of valuable works on anatomy and anthropology, died recently at Frankfort-on-the-Main.

Much opposition has developed against the Missouri State Board of Health, where shortcomings are attributed in part to the failure of the profession to give it hearty support, but a rather vigorous correspondent of the *St. Louis Courier of Medicine* charges it with incompetence and ignorance and says some of its members "could not tell a (latin) diploma from a death warrant."

The court-martial which was ordered to convene on March 9th, to try ex-Surgeon-General Wales, of the U. S. N., on the charge of culpable inefficiency and neglect of duty in connection with frauds in the Bureau of Medicine and Surgery during his term of office, has adjourned to meet April 14.

Dr. Ellerslie Wallace, one of the oldest and best known members of the medical profession of Philadelphia, died on March 9th. Dr. Wallace was born in 1819. He graduated from Jefferson Medical College in 1843, and for a number of years held the Chair of Obstetrics and Diseases of Women and Children in that school.

℞ Pulv. Acid. Boracic, gr. xviii; glycerini callid, ʒ i; ol. olivae, ʒ i. Recommended by C. J. Born, in *Brit. Med. Journ.*, as a splendid non-irritating and antiseptic dressing for extensive burns; also as a lubricant for catheters, sounds, etc.

Tickets to the Alumni Supper, University of Maryland, can be procured of members of the Executive Committee, Corresponding Secretary, Treasurer, or at the Medical Library. Price $1.25. The Association meets Commencement Day, March 17th. 8 P. M., at the Eutaw House.

The twenty-fourth annual commencement of Bellevue Hospital Medical College was held on March 9th.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from March 3, 1885, to March 9, 1885.

Byron, Chas. C., Maj. and Surg. Ordered to Dep. East, on expiration of his present leave of absence.

Brown, H. C., Maj. and Surg. Granted leave of absence for one month, with permission to apply for two months extension.

Woodruff, Ezra, Capt. and Asst. Surg. Ordered for duty at Fort Maginnis, Mont. T.

Porter, J. Y., Capt. and Asst. Surg. Sick leave of absence further extended fourteen days on account of sickness.

Ewing, C. B. 1st Lt. and Asst. Surg. Having relinquished unexpired portion of leave of absence, ordered for temporary duty in the field.

Raymond, Henry J., 1st Lt. and Asst. Surg. (recently appointed.) Ordered for duty in Dep. of California.

Original Article.

A SHORT NOTE ON TWO CASES OF STRICTURE OF THE RECTUM.*

BY OSCAR J. COSKERY, M.D., OF BALTIMORE.

In August, 1884, I was requested to see Mr. J. B., aged 43. The history of his case was, that during the last war in this country, while serving in the army, he became afflicted with hemorrhoids. Later, in 1877, an abscess made its appearance in the buttock, which, bursting at different points, left several sinuses; as these closed, it seems, with very little treatment, symptoms of difficulty in defecation came on, together with occasional discharges of blood *per anum*. These symptoms steadily increased until, when I first saw him, his condition was as follows: a tall, spare, dark-complexioned man, with dark hair and eyes, and an expression of countenance suggestive of habitual suffering. He had been complaining for a few days of what he called diarrhœa, but what, upon investigation, proved an almost incessant call to stool, though very little passed at each time, with great pain and some blood. By digital examination several distinct nodules were discovered, partially occluding the the lower part of the rectum, and, at about two inches above the anus, a hard ring which prevented the finger from penetrating farther, even although considerable force was used. On this account the extent of the constricting band could not be made out. Great pain was elicited by the examination, but very little bleeding followed. From the smooth feel of the stricturing band, though the patient was above suspicion, it was decided to put him upon specific treatment. This was faithfully carried out, but, in despite of occasional remissions, the patient steadily emaciated, the rectal symptoms increased, and upon making a second digital examination the obstruction was found to be greater. Believing that I had a case of malignant disease of the bowel to deal with, I advised colotomy. The patient only consented when his trouble had so increased as to make life unbearable. On November 7, 1884, I operated. The operation was exceedingly long and tedious, occupying fully an hour, because of the descending colon being, as I had not found it in former colotomies, contracted to the size of the little finger. It was not until, when from its anatomical position and relation to the kidney, I felt it could be no other portion of the intestinal canal, that I brought it out and stitched it to the skin. When the gut was opened no fæcal matter escaped. The wound was dressed in the usual way, and next morning a small quantity of fully formed fæces was found to have escaped. During the night of the second day a very large quantity came away. The wound, at first, did well; the patient, however, never did; a low form of peritonitis made its appearance, and on November 14th, exactly one week from the date of operation, the patient died.

On January 22, 1885, I was called to see Nellie B., aged 14, the youngest of three children of the above. The history of the case was as follows: Ever since she could remember she had had pain and difficulty in defecation; that about four years ago the nurse had first noticed a decrease in the size of the stool. These symptoms had lately become much worse, and now she spends an hour and upwards in the closet before she can feel that she has relieved herself. She, also, now suffers from occasional attacks of "cramps," irrespective of the efforts at stool. Her stools consist of bands of solid matter, generally with a small quantity of blood, sometimes only streaked, at other times there passes as much as a tablespoonful of free blood. The quantity varies as the difficulty in defecation, and is referred, by her, to the straining. The ribbons of fæcal matter are about one quarter of an inch broad by one eighth thick. The child was sallow, undersized for her age, had never menstrated, and was thin. Her general condition was what might be considered moderately good, but she was old-fashioned and "Paul Dombeyish" in her ways. Upon attempting a digital examination, great pain was elicited with spasm of the sphincters, and about one inch and a half above the anus a strong circular band was found, which would not admit my finger, perfectly smooth to the touch, and pressure upon which with the tip of the finger caused the child to scream (I should mention that she was very hysterical and nervous under the examination). No blood or fæcal matter was found upon the finger when withdrawn, but a small quan-

*Read before the Clinical Society, March 6, 1885.

tity of blood was passed by the patient very soon after. To allay the great irritability, a very small suppository of opium and belladonna was ordered. After continuing this alone for some weeks, with no improvement, the child was put upon cod liver oil, On March the 5th I found her wonderfully improved in general appearance. She is much stouter, has a good color, the rectal trouble has improved. Both she and her nurse state that the size of the *ribbon* has increased, and that she has passed no blood since taking the oil.

Society Reports.

OBSTETRICAL SOCIETY OF PHILA.

STATED MEETING HELD, MARCH 5, 1885.

The President, B. F. Baer, M.D., in the Chair.

Dr. Wm. Goodell read a paper entitled

A YEARS' WORK IN LAPAROTOMY.

During the past year he had had thirty-two laparotomies. Of these, twenty-two were ovariotomies, eight öophorectomies, one hysterectomy, and one exploratory incision.

Of the twenty-two ovariotomies, ten were performed in the hospital of the University of Pennsylvania, with three deaths; seven at his private hospital, with one death. In eleven, both ovaries were removed. Seventeen had adhesions, which, in seven, were very formidable. Four of the women were over sixty years of age, and of these one died. In not a single instance did he refuse to operate, although three of his patients were very ill at the time of the operation.

The causes of death were as follows An old lady, aged sixty-three, from whom a tumor weighing sixty-five pounds was removed, at the hospital of the University, died suddenly from acute uræmia, after doing well for three days. One kidney was found riddled with abscesses, the other was contracted. The second death also occurred at the same hospital, but from peritonitis, caused probably by hospitalism. The third and fourth fatal cases were in advanced stages of septicæmia when operated on. Each one had a high temperature, frequent pulse and night sweets from suppurating cysts. In addition, one was bed-ridden and had bed-sores. The other had greatly swollen legs, although the tumor was a small one. In each the adhesions were universal and very formidable. The former died from shock fifteen minutes after the operation. The latter lived one week. Here was a dermoid cyst, which, in his experience, was liable to have extensive and firm attachments, making removal often difficult and dangerous. Dermoid cysts also were very vulnerable, taking on inflammation on the slightest provocation. In this instance a physician had removed some of the fluid with a hypodermic needle. He (Dr. G.) had had two cases of small cyst in Douglas's pouch, in which violent inflammation followed the use of the aspirator. The lives of his patients were, for several days, in danger, but fortunately they recovered with obliteration of the sac. This should render one cautious about touching a dermoid cyst, unless he is prepared to perform the radical operation.

The fifth death occurred in a case forlorn from the outset. Five years ago Dr. Goodell had removed a very large colloid cyst of the left ovary from this woman. A year ago her health began to fail coincidently with the appearance of another abdominal tumor, and she was rapidly pulled down. On opening the abdomen, Dr. G. found that the cyst had burst sometime before, and that a colloid material had escaped in large quantities into the peritoneal cavity. The degeneration was plainly malignant, as the womb, broad ligament, bladder and the parietal peritoneum were studded with papillomatous masses. Dr. G. did not see her again, but her physician, Dr. Bauman, of Telford, wrote that the wound healed perfectly; no abnormal symptoms set in, yet the woman grew weaker and weaker, dying from exhaustion on the sixteenth day after the operation.

Dr. G. stated that this was the only case in which he twice performed ovariotomy in the same patient; but that he had at present a lady under treatment from whom, four years ago, he had removed the left ovary for cystic degeneration, and in whom the right ovary is now enlarging, and will need extirpation before long. The liability of the sound ovary becoming diseased, amounted in his cases to 1.5 per cent., and this strengthened him in the conviction

that in women approaching the climacteric, both ovaries should, as a rule, with but few exceptions, be removed. That this case made his third one of colloid degeneration in which the sac had burst sometime before the operation. In each the disease was evidently malignant. One survived the operation and went home, but died a few weeks later from a reaccumulation of colloid in the abdominal cavity and a sprouting out of a crop of papillomata from the cicatrix in the abdominal wall. In the second one both ovaries were removed, and from great emaciation and weakness the woman became plump and strong. She did well for two years, when a tumor made its appearance in the left broad ligament. A year later she died after much suffering. From this experience he would look upon colloid cyst with suspicion, and would give a guarded prognosis in respect to ultimate recovery.

With regard to the causation of ovarian cysts, he believed more and more that single life, sterility and unfruitfulness, whether natural or enforced, were important factors. Thus, out of his twenty-two cases, nine were unmarried, and one was a widow. Again, of the married, one was sterile, one had borne but one child, and three had had only two children.

During the past year he had also performed eight oöphorectomies. Three of these operations were demanded for excessive menorrhagia and dysmenorrhœa from multiple fibroids, and two of them died, the difficulties of the operation being great. The other oöphorectomies were performed for pernicious menstruation, ovaralgia and threatened miscarriage, and were successful. In no case did menstruation return, although in one there was a slight show of blood.

Of other laparotomies he had performed, two, one of them an exploratory incision in a woman greatly reduced by pain and obstruction of the bowels. Cancer of the pelvic organs was discovered. She died very suddenly from supposed embolism. The other laparotomy was a successful hysterectomy. The tumor weighed thirteen and one-half pounds, and consisted of the womb with many large fibroid growths. The adhesions to abdominal walls, bowels and omentum presented many difficulties, and needed many ligatures. The stump, which was fully four inches in diameter, was encircled by Kœberlé's wire clamp, and treated outside of the peritoneal cavity. The patient recovered slowly, and without bad symptoms.

The President presented a

GANGRENOUS FIBROID TUMOR OF THE UTERUS,

and made the following report of the case: Mrs. J., a patient of Dr. Jno. D. Canfield, of Renova, Pa.; fifty-two years of age; married; has had one child, eighteen years ago; she has not been pregnant since. Her abdomen had been rather prominent for years, and about five years ago she discovered that it was becoming quite firm and hard over the lower protuberant portion. About the same time her menses began to appear more frequently than usual and to continue longer, until during the past year, she flooded continuously three weeks out of every four. She thought she sometimes lost a quart of blood in twenty-four hours. There was great tenderness over the abdomen, so that the weight of the clothing was intolerable and she has a constant feeling of painful distension, a sensation of bursting sometimes. These symptoms increased in severity, and in the latter part of January, 1885, labor-like pains supervened. Paroxyms of uterine tenesmus occurred several times a day, resulting finally in a discharge of serous fluid and gas, which must have been considerable in quantity, for the next morning there was marked evidence of the previously distended abdomen. However, the large, dense, round, and evidently uterine tumor, still remained, tolerating now comparatively rough manipulation, the tenderness having almost entirely disappeared. The quasi labor-pains increased in frequency and strength, and shreddy putrid masses were occasionally expelled from the vagina. The patient began to show evidences of acute septicæmia. Dr. R. Armstrong, of Lockhaven, was now called in consultation, when it was determined that nature was endeavoring to cast off a decomposed uterine fibroid, and an effort was made to assist. Symptoms of blood poisoning became alarming.

On February 15th I was hurriedly summoned, and with the patient anæsthetized, we found the following condition: Abdomen distended and tymphanitic; a globular and symmetrical mass outlined within the lower portion of the abdomen, extending

two inches above the umbilicus, about the size and consistence of the pregnant uterus at the seventh month of gestation; hanging from the vaginal orifice was an elongated mass of toneless decomposing tissue, which resembled the appearance which might be presented by a great mass of amniotic membrane which had been allowed to remain in the parturient canal for several days after labor; it had a purplish, ashy color, and was as thick as my forearm. The odor emitted was sickening. Passing my hand beside this mass, for I could not easily separate it. I found the os uteri so dilated that the vaginal and cervix canals were almost of the same calibre, and the rim of the os could scarcely be defined. Advancing my hand within the cavity of the uterus, it passed among an immense quantity of semi-friable, soft and shreddy tissue, and discovered several large tumors of firm consistence imbedded in, and apparently one with, the uterine wall. Indeed, it was difficult to define the uterine wall, so irregular and thick was it at some points and so thin at others. The tissues at the attenuated portions—the uterine wall proper—appeared so weak, that I feared the manipulations necessary to enucleate the tumor would make rupture of the uterus imminent. But the irimmediate removal was imperative, and fortunately their attachments were softened by the process of degeneration which had caused the grave symptoms. I therefore introduced Thomas's spoon-saw, and with that, and my fingers, I separated and removed section after section until there was nothing left of the uterus but the merest shell. The aggregated quantity removed, a portion of which I present this evening, almost half-filled a wooden bucket. The uterus did not contract well after the operation, and very free hemorrhage occurred, but it was controlled, and the uterus made to contract by large and repeated injections of pure vinegar. The after treatment was carefully and judiciously conducted by Dr. Canfield, and consisted of injections, into the cavity, of vinegar twice daily, until all the fetid discharges had ceased. The improvement in the temperature and pulse of the patient was remarkable, and in a few days she expressed herself as feeling better than she had for years. She is now sitting up apparently restored to health.

Dr. Harris inquired the cause of the gangrenous change in the structure. Was it confined to the new tissue?

Dr. Goodell thought that the process of anti-enucleation was the cause of the degeneration of the tumor. The latter is a low grade of formation, and the contractions of the uterus and the constriction caused by the cervix-uteri around the already extended portion, interferred with the circulation in the tumor and it caused death. In one case he removed a tumor in which this process had just commenced; the removal of the tumor was followed by a gush of near half a pint of broken-down blood, which was very offensive in odor. A sharp attack of erysipelas followed.

Dr. Baer could give no other reason than that advanced by Dr. Goodell. The tumor was of slow growth; no ergot was given, but labor-like pains supervened, and may have cut off the circulation. The degeneration was apparently confined to the new growth.

The President presented the specimen, and read the following report of a rapidly growing

PAPILLOMATOUS OVARIAN CYST.

Mrs. G., æt 41; widow for eight years; has had eight children, the youngest being nine years. She always enjoyed robust health until September 1884, three months before I first saw her. At that time a slight metrorrhagia began without pain or other disturbance. Previous to that time her catamenial periods had been regular. In October she noticed that the lower portion of her abdomen was slightly enlarged a little to the left of the medium line. She thought nothing of it then, but thought that she was growing fat. The hypogastrium, however, continued to distend, and she began to lose flesh. Her physician, Dr. A. R. Blair, of York, Pa., brought her to see me on January 3, 1885. Her abdomen was then as large as at the sixth month of gestation, symmetrically developed, perfectly smooth, dull on percussion over the distended portion, but resonant in flanks and epigastrium, and there were marked fluctuation; dark bloody discharge from uterus, not fetid. It was thought that she was pregnant, and that the metrorrhagia was due to threatened miscarriage. But she was losing flesh, and there were no rational or physical signs of pregnancy, except ab-

dominal enlargement. The uterus was slightly prolapsed and retroverted, rather softer than natural, os patulous, cervix granular, sound two-and-a-half inches; uterus not easily moved, because of a mass pressing on it from above. I diagnosticated a rapidly growing ovarian cyst, aud advised immediate operation; but she was not ready. I saw her again on February 7th. The tumor had increased to double the size it was at first examination. It was still symmetrical and occupied the same relation to the uterus. She was losing flesh and strength. She now complained of pain all over anterior surface of abdomen, and her pulse and temperature were slightly elevated. She at no time suffered pain in the tumor.

On February 18th she entered my private hospital. Has increased greatly in size during the intervening ten days; circumference at umbilicus forty-six inches; veins in abdominal wall distended; tumor still symmetrical and markedly fluctuating; metrorrhagia has continued daily since its first appearance in September; suffers from dyspnœa; pain over surface as before, and abdominal wall seems to be one with the tumor. I suspected from this circumstance adhesions of tumor to peritoneum; urine normal.

Operation, February 20th, 11 A. M., assisted by Drs. D. J. M. Miller, and J. C. Gabell, in the presence of Drs. A. R. Blair, J. W. Kerr and B. F. Hazel. Incision three inches; tumor almost universally adherent to anterior wall of abdomen and omentum, and very vascular. I passed my hand and separated adhesions and then tapped the cyst; the fluid had the colored consistence of healthy pus and was more than an ordinary woodenpailful in quantity. Solid portion of tumor larger than the fœtal head at term was delivered through the small incision. The tumor proved to be of the left ovary and had a very short and vascular pedicle which held it in close contact with the uterus. Ligated and amputated omentum, transfixed and ligated the pedicle with fine Chinese silk, cut and dropped. The right ovary being perfectly healthy was not removed. The uterus was soft and congested. Peritoneum purple from congestion, but there had been no ascitic fluid, and the peritoneal cavity was found almost free from liquid. Probably ten minutes were spent looking for bleeding vessels and finishing the "toilette of the peritoneum." Abdominal wound then closed with eight silk sutures. The patient recovered from the anæsthetic without any evidence of shock; pulse 98; temperature normal, and she continued to do well until the second day, in the evening of which her temperature reached 100°, its highest point, pulse 108 and strong. She complained of being tired and looked worn. She had not passed flatus from the anus, but there were occasional eructations of foul gas. There was no tympany and no pain, but at about 11 P. M. she vomited or rather regurgitated about a pint of fetid yellowish liquid of a decidedly fæcal odor. The large quantity (she had not taken a teaspoonful of anything since the operation) and the odor, together with the fact that she had not passed flatus from the anus caused me to suspect intestinal obstruction. Her temperature fell soon after this to 96°, and her pulse rose to 130, and became very weak. There was no palor of countenance, or distention of abdomen or Douglass's cul-de-sac, or I should have thought this depression, bordering on collapse, was due to hemorrhage. Neither were there any other symptoms of intestinal obstruction than the apparent fæcal vomiting and the non-escape of flatus from the rectum.

Under the influence of active stimulus, by the rectum and hypodermically, she slowly rallied, but the temperature did not reach the normal point until the fifth day after the operation, when flatus began to escape from the rectum. Her recovery was rapid after this. The sutures were removed on the eighth day. Union complete and solid. She sat up on the thirteenth day. There has not been any bloody discharge from the uterus since the operation.

The tissues of the cyst-wall are very friable, and the internal surface is studded with an exuberant papillary growth, presenting an appearance not unlike cauliflower excresence.

The very rapid growth of this tumor to the great size which it attained in five months, the constant metorrhagia and the character of the tumor, place this case quite out of the usual course of development of ovarian cysts and make it worthy of record. These are characteristics of malignant disease. Is this a malignant tumor? I think not in the sense of that it will necessarily return, now that it has been removed before the cyst-wall had broken down and dis-

charged its contents into the peritoneal cavity. This is the course of papillomatous ovarian cysts. But even when this has occurred and the peritoneum become involved, the disease may not return after removal. Some years ago I assisted Dr. Goodell in the removal of a papillary growth of the ovary in which the cyst had ruptured and discharged its contents into the peritoneal cavity. The peritoneum was greatly involved, being thickly studded at various points with hard papillary nodules. The patient recovered and the disease has not returned. Dr. Emmet records a like experience. He says: "I have never regarded the condition as malignant in character or in any respect more than a benign growth, accidental to ovarian tumors and accompanied by an ascitic accumulation" (ascites complicates a later stage of the disease than my case had reached) "I have, however, sometimes observed in this supposed malignant disease that patients bore the shock of the operation badly and died from apparently trivial causes." *Prin. and Prac. of Gynecol., third edition, p.* 683. It is probable that ovarian cysts of very rapid development often have this papillary character. One of the specimens which I presented to this Society at its last meeting was of this description, though less marked; and it has attained a size of thirty pounds in nine months. It is also probable that the constitution is more profoundly affected by these growths than by the ordinary slow-growing ovarian cysts. For these reasons operation should never be deferred in such tumors.

Dr. Harris inquired whether any microscopic examination of the tumor had been made. He always suspected malignancy in rapid growths, and in papillomatous tumors the disease cannot be made from appearances as of two such having the same apparent characters one may prove to be malignant and the other benign.

Dr. Goodell remarked that the question of malignancy in ovarian tumors was a most interesting one. As regards papillomatous cysts: Doran had divided them into two classes; one springing from the pilus of the ovary and not necessarily malignant; while papillary growths in cysts of the broad ligament usually indicate malignancy. Some years ago he removed a collapsed papillomatous ovarian cyst, upon which the late Dr. Hodge had refused to operate in consequence of supposed malignancy. It was complicated by ascites, and the peritoneal cavity had been infected with secondary growth; yet the woman got well and has probably remained well. On the other hand, benign looking growths were sometimes malignant; for instance, he removed a large tumor having many adhesions, twenty-four ligatures were left in the abdominal cavity. It was wholly benign in appearance and the patient got up and about, but soon she became oppressed by rapid breathing. Effusion into the right pleura was discovered together with malignant growths affecting that cavity and scattered throughout the abdominal cavity. The tumor was evidently malignant, but it did not look so. In another case of apparently benign cyst, in which the clamp was used, menstruation occurred from the cicatrix, and, later, papilloma of the stump and abdomen sprouted out from the cicatrix and the patient died. He said that all his cases of colloid tumors, three in number, have become malignant afterwards. In one case, five years after first operation, the second ovary became decreased, the sac burst and the whole contents of the peritoneal cavity became infected.

In another, two years after the removal of both ovaries, the disease returned in the broad ligament, probably from the stump of the ovary. In another case the cicatrix burst open a few weeks after the operation and a large papillomatous growth sprouted out, the lady dying soon after. Tait considered that among the causes of malignancy are tapping and delay in operating; the age of the cyst tending to malignancy. Dr. G. doubts if the microscope can distinguish between benign and malignant papillomata. Virchow states that although benign at the beginning, they may become malignant in the later stages.

In order to settle the relations of the comma-bacillus to cholera two Italian gentlemen offer, through the *Deritto*, a newspaper of Rome, "to eat such a quantity of gelatine containing the *microbe* as a scientific commission may judge sufficient to determine the development of cholera, upon condition only that their names be absolutely incognito, and that in case of their death the government or some rich philanthropist take charge of their families.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD FEBRUARY 12TH, 1885.

The President, DR. SHAKESPEARE, in the Chair.

Dr. Joseph S. Neff presented

A CASE OF CARDIAC (?) ANEURISM.

William N., colored, aged 40; family record good; no evidence of venereal disease. His previous history shows nothing of importance until two-and-one-half years ago, when he had acute inflammatory rheumatism; I could not obtain any satisfactory history of endo or pericardial inflammation at that time. He appeared to make a good recovery and remained well until one-and-one-half years ago, when he noticed palpitation of the heart and dyspnœa upon slight exertion, soon followed by cough, which was rather persistent. There was no œdema at this time, at least not sufficient to have attracted his attention. He improved upon rest and some medication received at a dispensary. After this first attack, until admission to the Philadelphia Hospital, he was enabled to work, although being always susceptible to palpitation and shortness of breathing upon extraordinary exertion with one exception, which was one of his so-called attacks and described as "catching cold," which would increase the above-named symptoms to such an extent that he was compelled to remain in the house for several weeks last August. Here again there was no sudden exacerbations of the symptoms alluded to.

He was admitted to the medical ward of the hospital on the 25th of November, 1884. at which time he presented the following conditions:

Orthopnœa intense, cough persistent and troublesome accompanied by hæmoptysis, palpitation of the heart excited by moving in bed, general anasarca, skin on limbs and scrotum cracking in places from distention, deep pitting on pressure even on chest, face and forehead, bowels constipated, urine scanty, containing one-tenth of one per cent. of albumen, no cysts. Pulse weak and frequent, although the peculiarity known as corrigans pulse was distinguishable.

Physical examination revealed marked and peculiar pulsation of the great vessels of the neck. Impulse of heart seen disseminated over an area of about two inches. Cardiac dulness extended from upper border of the third rib on left side of sternum to liver and horizontally on a line of fifth rib from ¾ inch to the right to 4½ inches to the left of sternum. The apex beat being felt in the seventh interspace (1½ inch to the left and 2½ below the nipple).

Upon auscultation a loud blowing diastolic murmur was heard commencing immediately below the aortic valves on a level with third rib and transmitted downward toward the left, being quite loud at the ensiform cartilage and apex, with its seat of greatest intensity over the left side of sternum on a level with the fourth costal cartilage. This murmur was not transmitted in any other direction.

As to its exact time I would state that it commenced immediately after the first sound lasting through the second and continuing almost through the period of rest.

A systolic murmur was also heard at the base of heart and was transmitted towards both infra-clavicular regions, and at times was heard in the carotids. It commenced with the first sound, but did not last through it. It was not heard over the body of the heart. In the region of the apex a third murmur was heard, systolic, which could be clearly separated from the preceding as being less harsh and occurring later in the systole. It was also heard over the left auricle and as far to the left as the axillary line. Was not audible posteriorly.

Physical examination of the lungs showed a condition of passive congestion. There were no nervous phenomena excepting some slight delirium, lasting for a short time and due to imperfect æration of blood.

The diagnosis was undoubted aortic insufficiency with dilated hypertrophy of left ventricle and some mitral regurgitation. Under treatment improvement commenced at once and continued until December 11th, when he was able to walk around the ward without discomfort. Cough had disappeared; no shortness of breathing or palpitation without undue exertion; dropsy almost entirely absent; the urine still contained a trace of albumen. Physical signs of the heart were unchanged save an impulse increased in force. Pulse was 78, strong and retaining to a marked degree the "trip hammer" characteristic.

The general condition remained un-

changed until December 30th, when it was noticed that the œdema was making headway, returning dyspnœa, etc. This gradual increase in severity of symptoms continued, and on January 5th there was constant hæmoptysis, the physical signs being the same again as on admission, excepting dulness and bronchial breathing over both bases of the lungs posteriorly.

Patient gradually grew worse and died on January 19th.

Autopsy made by Dr. Shakespeare, the pathologist of the hospital, the notes of which were written by my resident Dr. Hickman, and are as follows:

External Appearances.—General anasarca, especially of lower extremities, most marked in the left.

Heart.—Pericardial cavity contained some serous fluid but no evidences of pericarditis. The heart was greatly enlarged. The enlargement being principally in left ventricle.

Right ventricle contained dark clotted blood, the wall being ¼ inch in thickness, very firm, and marked post-mortem staining present. Nothing else noteworthy on this side.

Left ventricle was greatly dilated and the wall much hypertrophied, being fully ¾ inch thick. The endocardium was intensely stained post-mortem. Ventricular wall was quite soft. The ascending aorta also showed intense post-mortem staining of inner lining, and the latter was in a condition of moderately extensive arteritis.

Coronary arteries appeared normal at their mouths, the right being somewhat dilated and more or less atheromatous. Mitral orifice appeared normal also the surface of the auricle. The ventricular endocardium presented nothing noteworthy except post-mortem staining.

There were on anterior leaflets of mitral valve, at base, a few endocardial yellow streaks running horizontally. At juncture of left cusp of aortic valve with ventricular cusp there was a mass of cheesy material beneath the endocardium about ½ inch diameter. The mitral cusp showed a rupture through and into the pocket of posterior cusp where the two joined. The latter cusp was also perforated in its right third; there was an aneurismal cavity extending into upper portion of septum between the ventricles. The apex of the dilatation corresponded to the upper septum of right ventricle, the aneurismal sac showed a dilatation towards left ventricle and a rupture into the latter by an orifice admitting the end of a thumb, the upper border of the opening being formed by the two affected leaflets above mentioned. There were some vegetations upon the under surface of aortic cusp. The aneurism was the size of a walnut and contained no clots. Both pleural cavities contained sero-sanious fluid. No adhesions except in one point at lower lobe. The two lobes were slightly collapsed; they presented no other abnormal appearance except the existence of two embolic infarcts one small wedged-shaped, size of a hazelnut, superficial near the inner edge of upper lobe at its anterior surface; pleural surface congested. Another, the size of a hen's egg, projected above the surface at the inner edge of lower, and at the outer edge of upper lobe, about two inches from base of lower lobe, at its anterior aspect. The two lobes were adherent at the point of the suface, and their substance appeared to run together. The cut surface showed the infarction to be made up of tissue of both lobes, mainly of lower; and a line of division of the two lobes was quite perceptible. The area of infarct was dark-red and granular, sharply outlined. At the centre of the pleural surface of this large infarct there was an irregular area of reddish substance. No pleuritic adhesions within chest wall corresponded to this infarct and no decided pleuritis.

The upper lobe of right side contained two infarcts, size of a hickory-nut, along its anterior lower edge; middle lobe one in a similar position: Lower lobe contained four varying in size. This lung presented nothing else abnormal.

Liver normal in size, flabby and smooth; nothing else abnormal except some congestion and probable increase of fibrous tissue, it being extremely difficult to push finger in the cut surface.

Spleen normal in size, pulpy, dark-brown in color with with slightly increased thickness of the capsule.

The kidneys were normal in size and presented no marked unhealthy appearanee, these organs being so stained post-mortem as to make it impossible to judge of their condition; amount of cortex appears normal.

The pathological change seemed to originate at the sinus of Valsava and penetrate into the septum, then causing a bulging of the two affected aorta leaflets making a

valvular aneurism (secondary) which ruptured into left ventricle. Clinically, these cases are of little value, as none have been diagnosed other than valvular disease. It seems quite remarkable, however, that there was no sudden onset of symptoms to mark the rupture of valves.

DISCUSSION.

Dr. Tyson said that the aneurism seemed to have its origin in the sinus of Valsalva whence it had dissected the muscular tissue of the heart towards the base of one of the leaflets of the tricuspid valves without perforating into the cavity of the right ventricle. The perforation of the semilunar valves of the aorta he thought secondary, for if it had exerted its force primarily in this direction, it would have perforated into the left ventricle. The origin of the infarcts does not seem at all clear. They ought, of course, to have come from the right side, as they were of large size and could, therefore, hardly have come around from the left heart through the systemic capillaries into the right heart and thence into the lungs.

Dr. Hughes said that we might perhaps explain the infarctions by means of the bronchial arteries, as this was the route said to be pursued by emboli to the lungs.

Dr. Neff said that this œdema as described was rather remarkable, but the notes would show that there was albuminuria in addition to the enfeebled circulation and pulmonary congestion; this œdema of the upper extremity was not constant. As far as the infarcts were concerned, he was anatomically at a loss. In his mind they were always directly connected with the lesions in the left heart, as it was difficult to see how the necessary thrombi could originate in the right side as the post-mortem revealed no signs of disease here excepting the projection of the aneurismal bulging, which evidently did not interfere with the circulation. Congenital aneurisms, as described by Peacock and others, were lower down, as a rule, in the undefended space, and they were rarely, if ever, the direct cause of death, unless accompanied by endocarditis. The rupture of the cusps was due to their weakened condition, dependent upon calcareous degeneration.

Dr. Tyson was much struck with the explanation given by Dr. Hughes as to the origin of the infarcts, and thought that we paid too little attention to the bronchial arteries as a factor in pulmonary infarction.

Dr. Shakespeare agreed with Dr. Hughes, and thought that Cohnheim, through his celebrated study of the embolic processes, had shown that pulmonary infarction usually takes place by way of the bronchial arteries, which are, according to him, of a terminal character.

Dr. James Tyson presented the following case:

SARCOMA OF RETRO-PERITONEAL GLANDS.

Samuel D., a gardener, aged 43, unmarried, was admitted to the Philadelphia Hospital, August 15th, 1884. There was no family history of phthisis or cancer, nor has he ever had syphilis. Three years ago he had a tertian intermittent fever, which lasted a week only. He thought he had injured himself by heavy lifting in June, 1884, and dated his illness from that time, although he admitted having experienced some discomfort prior to that time in the constant stooping that his occupation required of him. About July 1st he noted that his feet and legs had begun to swell; also that the swelling would partially disappear at night. At this time he also began to have, at regular intervals, severe pain in his legs, especially the left leg. He was subject to alternate constipation and diarrhœa. This was about his condition when admitted. There was also noted a swelling immediately below the edge of the ribs on the right side, which was ascribed to enlargement of the liver, the dulness occasioned by it being directly continuous with that of the latter organ. His condition changed slowly, but gradually the tumor became more evident and the pain in the right leg increased. He was certain, when admitted, there was more pain in the left, and that at that time could not lie on the right side, while by November 20th he could rest more comfortably on that side. At this time the dulness extended in the mammillary line from the sixth rib to a line drawn transversely from a point one inch above the anterior superior spinous process of the ilium. In the middle axillary line, the dulness extended from the ninth rib to the crest of the ilium, and posteriorly, from the eleventh rib to the same point. The tumor was bounded on the left

and below by a line drawn from the umbilicus to a point one inch above the anterior superior process of the ilium and thence obliquely to that bone. There was distinct bulging in the left flank and right lumbar region. The circumference of the abdomen, through the umbilicus, was thirty-four inches. There was greater fulness in the right flank laterally and posteriorly, and the veins over this region and the right half of the abdomen were distended. From December 1st he was confined to his bed, being unable to stand in consequence of what he described as weakness in his legs, especially the right, and he suffered so much pain as to require the regular administration of morphia. The circumference through the umbilicus was thirty-six inches. The sulcus at the border of the ribs had become more marked. There was at no time jaundice, and while he gradually emaciated there was no cachexia.

At first no thought was entertained that did not suppose the tumor was in some way associated with the liver. Abscess, lardaceous disease and cancer were, however, excluded by the absence ot the other essential symptoms, and it was finally thought that we had most likely to do with a hydatid cyst. This was based upon an obscure sense of fluctuation at the most prominent part of the swelling to the right of the umbilicus. Accordingly, on December 12th I introduced an exploratory needle to the depth of four inches at this prominent spot. A few drops of bloody fluid only were drawn, which proved upon microscopic examination to contain no distinctive elements. Forced by the results of this operation to abandon the liver as the seat of the disease the kidney was then selected as it's probable seat, although repeated examinations of the urine had shown that it, while it was somewhat diminished in quantity, was otherwise normal. It was ascertained, however, twice, that it did not contain iodine after the administration of five grains of this substance. Soon after the first of January, 1885, his stomach ceased to retain food, after which he declined more rapidly and died January 16th. As the disease progressed the tumor presented through the abdominal walls, and also to palpation, a more uneven outline, which could not, however, be described as nodules. At the autopsy there was noted on inspection œdema of the right leg and a tumor occupying the space between the ribs and ilium on the right side, extending three inches beyond the median line. It was bumpy or uneven. The hand could be pushed up a short distance between the ribs and the surface of the tumor. On section the visceral and parietal peritoneum appeared normal, and the omentum partially covered the abdominal contents, but was adherent only in the right iliac fossa. The colon was displaced, and commencing at its head in nearly the normal situation in the right iliac region, extended upwards and to the left along the border of the tumor mass, to the region of the spleen, where it turned inwards and made two or three twists along the left side of the abdomen. The right side of the liver was slightly enlarged, but the organ was otherwise normal. There were no adhesions whatever and its surface was smooth. It was unusually firm on section, and the lobules seemed to have been compressed.

The spleen was slightly harder than usual, but otherwise normal. The pancreas and stomach were both placed backwards and to the left. The former was normal, as was the latter, except that there were a few punctiform extravasations in the cardiac end.

The left kidney was found buried beneath the left portion of the tumor, and appeared one-third larger than normal. The capsule stripped off easily, leaving a smooth, dark surface. On section the cortex seemed slightly harder than in health and was darker in hue. The sections studied microscopically showed a normal histology. The organ was simply hypertrophied.

The right kidney was found closely applied to the front of the tumor, and so closely that it was at first overlooked and the tumor thought to be one of that kidney. It was compressed, flattened, thinner than an average hand, and smaller in circumference than the normal organ. The minute examination of the right kidney revealed a very interesting condition. The tubules bore evidence of the compression to which the organ had been subjected. The cells were everywhere compressed and the tubules narrowed. There was a slight hyperplasia of intertubular tissue, especially about the malpighian bodies. The ureters and bladder were normal.

The pericardium and heart were normal; the *left pleural sac* contained a small quan-

tity of bloody serum, and there were a few trifling adhesions.

The *left lung* contained along the outer anterior edge of the upper lobe, three inches from its base, a moderately firm nodule ½ inch in diameter, pinkish-grey on section and projecting above the adjacent cut surface of the lung. Two similar reddish-grey nodules were found on the lateral aspect of the lower lobes of the lung, about four inch from its base. They were about an inch apart, about ¾ inch in diameter and projecting as much from the lung almost as sessile tumors. There was another small tumor on the posterior edge of the base of the lobe. There was more than the usual adhesion between the two lobes of the lung. The lower lobe of the right lung was much adherent to the diaphragmatic as well as the thoracic pleura. There was a warty excrescence about ¾ of an inch in diameter attached by a small pedicle to the upper lobe and a still smaller one at its anterior edge. The nodules in both lungs were encapsuled. The *tumor* itself was lobulated and occupied the entire right side between the edge of the ribs and the pelvic bones and extended even to the left of the median line in the neighborhood of the umbilicus. It presented the same obscure sense of fluctuation, and upon section the lobes of which it was composed, each one of which appeared to correspond with an original lymphatic gland, protruded in its central position, and presented a uniform pinkish-grey surface moderately soft but by no means diffluent in consistence. The microscopic examination revealed throughout the structure of a sarcoma.

DISCUSSION.

Dr. J. H. Musser asked whether the tumor moved synchonously with the respiratory movement, for if connected with the liver, such would be the case. He would also like to know whether hydatid fremitus, so-called, was present, and by what sign was the diagnosis of hydatid tumors made.

Dr. Musser also asked the position of the left lobe of the liver, for if displaced it would have indicated possible dislocation of that organ, a condition well-known to ensue in tumors of the right kidney on account of the direction of their growth. He thought a tumor of the right kidney could have been eliminated by the direction of the growth of the present tumor, viz., downwards and outwards.

Dr. Tyson said that with regard to its mobility it was certainly a fixed tumor. There were no signs of hydatid fremitus, this diagnosis having been arrived at by exclusion, and the obscure sense of fluctuation which could be detected.

Dr. Shakespeare said there was also a small lobulated tumor on the left side of the vertebral column entirely covered and concealed from view by the fibres of the head and belly of the left psoas muscle. He suggested that the origin of the larger right-sided tumor may possibly be explained in the same way, for not only the kidney and ureter, but also the large vessels were pushed forward, and to the left border of the tumor mass, and the remains of the head or belly of the right psoas muscle could be found. The location of the retro-peritoneal glands of the lumbar region is mainly in front of and around the main vessels. They are far in front of the psoas muscle, and can with difficulty, under all the circumstances of this case, be regarded as the origin of this tumor.

Dr. Shakespeare would ask Dr. Tyson whether the pain complained of was referred to the anterior crural, or the sciatic nerves.

Dr. Tyson replied that he would not be certain whether the pain in the left leg was along the distribution of the anterior crural, but thought it was. Certainly in the right leg the pain pursued the course of the branches of distribution of the sciatic nerve.

Dr. W. A. Edwards presented a

LARYNX, TRACHEA, LUNGS AND HEART FROM A CASE OF DIPHTHERIA.

This case occurred in the practice of Dr. Wm. M. Powell, of this city, at whose request I saw the little patient, and for whom I made the post-morten examination. Lizzie P., æt two years, of a strumous diathesis, was first seen by Dr. Powell on February 2, 1885, when she appeared to be suffering from catarrhal fever, but at his next visit, two days later, a diphtheritic membrane was easily recognized over the uvula, tonsils, and arches.

The child grew worse, the membrane increasing; the cervical and post-cervical glands enlarging; pulse running high; hy-

perpyrexia, and the case rapidly assuming a malignant aspect. On last Sunday, the 8th, after consultation, the plan of treatment was slightly changed, apparently to the child's benefit, as she improved until about eight in the evening of the 11th, when her respiration was noticed to become fish-like; extremities cold; pulse high and thready; increasing apnœa, and sudden death at 9.30 P. M. *Post-mortem* fourteen hours after death.

Female child; fairly well nourished; in the right eye to be seen a corneal opacity, probably the cicatrix following phlyctenular keratitis. The larynx unfortunately, was somewhat mutilated in removal, as an incision in the neck was not permitted. Some œdema may be noted, and in the recent state areas of hyperæmia were observed, probably the seat of membrane. The trachea presents these areas more plainly. The glands at the root of the lungs and along the trachea are much enlarged and indurated; one is lodged just at the bifucation of the trachea, and probably had some causal relation, through pressure to the emphysematous condition of the lungs. Thorax, lungs: the pulmonary and costal pleura are adherent, as also the diaphragm; the lobes of the lungs are bound together by slight adhesion. In numerous spots over the lung tissue are to be seen small areas of emphysematous dilatation. Cross sections of the bronchiæ show exuding muco-purulent matter well aerated. No effusion is to be seen in the pleural cavities. The heart appears to have undergone some dilatation of its right cavities, the valves are normal, the left side is firmly contracted with normal valves. Contrary to our expectation, no clots were seen either in the heart, pulmonary arteries or aorta, with the exception of a very small one entangled in the chordæ tendineæ of the right ventricle. No effusion within the pericardium. Liver, normal; spleen somewhat enlarged. Stomach contained a large quantity of undigested milk; over its surface are seen numerous centres of ecchymoses. Kidneys and brain next examined.

The cause of death in this case becomes an interesting inquiry; the child was practically well of the diphtheria, and was progressing nicely towards convalescence, when suddenly signs of apnœa appear, deepening into death. As was noted above, the right auricle and ventricle appear to have undergone some dilatation; this, to my mind, was the cause of death in our patient's case, as *sudden and considerable dilatation of the cardiac cavities, more especially of the right heart*, may be remarked at the bed-side, and in many febrile cases, cause sudden death from heart failure.

Dr. Tyson said that the cause of death in diphtheria seemed best explained by the theory of Dr. Edwards, which is a very reasonable one, and that this dilatation of the heart cavities was the result of a rapid fatty degeneration of the heart muscle, a condition of frequent occurrence. Theoretically, digitalis was considered useful in this form of heart failure, but if due to fatty degeneration, it would, of course, produce no effect. Affections of the cardiac ganglia he did believe produced this heart dilatation.

Dr. Edwards said that Dr. Beverly Robinson had reported examinations in which he could find no fatty degeneration, and Dr. Edwards himself, in three cases of rapid dilatation of the right cavities occurring in typhoid fever, had failed to find evidences of fatty degeneration; these cases were published in the medical journals about one year ago.

Hairy Vaccination.—*M. P. Diday* (*Lyon Méd.*) describes the case of a healthy child, 11½ months old, who was vaccinated with animal vaccine furnished by the municipality of Lyons. The matter was introduced by two punctures on the anterior surface of the middle third of each thigh. The local inflammation was quite considerable, but the vesicle developed regularly and ran its proper course. Sixty days later, however, a crown of hairs made its appearance about the cicatrix. From being delicate, downy, and nearly colorless at first, they soon took on length, color and body. Four months later there was presented the curious spectacle of a still reddish cicatrix, surrounded by a double and triple row of hairs, six to eight mm. in length, the color of which, like the hairs of a red cow, stood out in bold contrast against the absolutely smooth skin of the child. The plate which carried the matter being carefully examined, was found to contained three or four small hairs, visible to the naked eye.—*Louisville Med. News.*

Editorial.

THE DUTY OF THE MEDICAL PROFESSION IN RESPECT TO PATENT NOSTRUMS.—In a previous issue of this JOURNAL we took occasion to condemn in very plain language the action of the Health Commissioner, of this city, for having publicly endorsed a patent medicine which is being extensively advertised and sold as a cure for every manner of coughs and colds.

We have received assurances from many readers of the JOURNAL approving of our position in this matter and urging a further discussion of this subject. It seems advisable that we should supplement our former views on this important subject, with a statement defining the duty of the profession in respect to the patent nostrum trade. It is quite evident that many physicians fail to see the impropriety of endorsing and prescribing patent nostrums. We know it to be a fact that members of our profession are not only using these nostrums in their practice but openly recommend them to their patients. This practice prevails more generally among country practitioners than among those who experience the rivalry of sharp competition in the cities, but it exists more or less among medical practitioners in various localities. The reason for this loose method of prescribing remedies is easily found. Many physicians are in the habit of accepting all kinds of statements, lauding the value of remedies, whether these statements are made in the columns of regular medical publications by medical writers, or whether made by the loud-mouthed proprietors of the nostrum trade in the columns of their perennial almanacs. The proprietor of a patent nostrum has only one object in view; that is to secure a purchaser for his so-called remedy. His energies are all expended in advertising the marvellous curative properties of his goods, and their virtues are only exceeded by his cold-blooded impudence and boastful assurance. He is willing to entrap any and everybody who will believe his stories. He addresses his choice literary and scientific productions to the needs of his different readers, and very adroitly convinces those, willing to be convinced, that he possesses a panacea for every ill. We regret to make the assertion that members of our own profession are entrapped and taken in by these venders of remedies whose constituents and proportions are locked up under a formula secured by a government patent. The physician who prescribes or recommends a patent nostrum is giving direct support to a remedy about which he has no positive knowledge and which may contain agents which will produce an effect just the reverse of the one desired. He has no assurance that his use of such remedies may not produce disastrous consequences to his patients. We will grant that his experience with a nostrum may be such as to commend it to his favorable consideration in certain cases. Can this experience justify its use in any other condition where a definite action is desired, or can he, in justice to his patients, advocate its indiscriminate use by endorsing its action in any condition? It seems to us that no intelligent physician can find a valid argument that will sustain him in the use of patent medicines. The whole system of therapeutics is based upon a study and a knowledge of the action of remedies. In the application of remedies to disease there should be no indefiniteness. The physician must know what he is using, the quantity and quality, as well as the effect desired. The employment then of indefinite or unknown combinations is nothing, short of a therapeutic nihilism.

The indiscriminate and careless use of drugs is an outgrowth of an overweening confidence in the curative value of medicinal agents. There are members of our profession who believe that medicines are universal panaceas for every ailment. They give their patients any and every kind of combination to be devised, and when the pharmacopœia is exhausted, the aid of the nostrum vender is invoked. Such men never call a halt, but vainly test the resources of the drug shop until nature calls their patient into rest.

It is time that more conservative and rational views of therapeutics were disseminated, and we would gladly welcome, not only a warfare upon the proprietors of the nostrum trade, but upon those false methods of practice which discard a scientific therapy, and hunt diseases with remedies with as dreadful a precision and vigorous an onslaught as if administered from the muzzle of double-barrelled shot-gun.

Turning again to the purport of our remarks, the support given to the nostrum trade by physicians is not only wrong, but

is in the highest degree prejudicial to professional interests. The physician who lends his influence and support to such remedies, should consider well what he is doing. Upon this subject the code of ethics of the American Medical Association utters no uncertain words. It distinctly says, "equally derogatory to professional character is it for a physician to hold a patent for any surgical instrument or medicine; or to dispense a secret *nostrum*, whether it be the composition or exclusive property of himself or others. For, if such nostrum be of real efficacy, any concealment regarding it is inconsistent with beneficence and professional liberality, and if mystery alone give it value and importance, such craft implies either disgraceful ignorance or fraudulent avarice. It is also reprehensible for physicians to give certificates attesting the efficacy of patent or secret medicines, or in any way to promote the use of them."

"It is the duty of physicians, who are frequent witnesses of the enormities committed by quackery, and the injury to health, and even destruction of life, caused by the use of quack medicines, to enlighten the public on these subjects, to expose the injuries sustained by the unwary from the devices and pretensions of artful empirics and imposters."

We fail to see how language can express more explicitly the duty of the profession in respect to the patent nostrum trade than that quoted. We therefore commend these words to the consideration of any of our readers who may differ with us in regard to the importance of this subject.

The Medical Status of Baltimore.—The following from the preamble to the charter of the Royal College of Physicians of England, which was established in the reign of Henry VIII, with a little variation, might apply, not inaptly, to the medical status of Baltimore at this time: "The science and cunning of physic and surgerie, to the perfect knowledge whereof are requisite both great learning and ripe experience, is daily within this realm exercised by a great multitude of ignorant persons, of whom the greater number have no manner of insight in the same, nor in other kind of learning. Some, also, can read no letters in the books, so far forth, that common artificers, as smiths, weavers, and women boldly and accustomedly take upon them great cures and things of great difficulty, in which they partly use sorceries and witch-craft, and partly apply such medicines unto the diseased as are very noisome, and nothing meet therefor to the high displeasure of God, etc., and destruction of the King's liege people."

Schools of Biology.—The *St. Louis Courier of Medicine* speaks of the School of Biology established in connection with the University of Pennsylvania as the only institution of this sort in America. This is conveying a false impression, as the Biological Laboratory of the Johns Hopkins University, under Prof. Martin, has been in operation, in this city, for more than eight years; is provided with every appliance necessary for the teaching of that subject, and has already achieved a world-wide reputation.

Prof. Martin pronounces the new building recently erected for his Biological department, as, "for its purpose, unrivalled in the United States, and not surpassed in the world," and doubtless his language may be accepted as in every respect absolutely true.

Corrected Statement.—In the publication of a letter adressed by Prof. L. McLane Tiffany to the editor of the *North Carolina Medical Journal*, which appeared in our issue of March 14th, pages 389–90, a typographical error occurs which destroys the entire meaning intended to be conveyed by the writer. We make Prof. Tiffany say: "I will reply specifically to such statements and insinuations as refer to me—statements and insinuations which, I regret to say, do appear to be justified by the facts." The last sentence should have read "statements and insinuations which, I regret to say, do *not* appear to be justified by the facts."

Lemon-Juice in Malaria.—*Dr. Putokhin*, of Mosalsk, (*Russkaia Meditzina*), eulogises decoction of lemons as a cheap substitute for quinine in intermittent fever. It is prepared by cutting a lemon in slices, putting it into three glasses of water and boiling until one glass of liquid remains. Dose: a tablespoonful every one or two hours in half glass of boiled water, to which sometimes a few drops of opium are added to prevent any possible irritation of stomach.—*Lond. Med. Record.*

Miscellany.

Treatment of Cholera.—*Dr. John C. Peters*, of New York, (*Med. Record*, March 14), thus sums up the modern treatment of cholera, a subject upon which he may be regarded as a specialist: Hypodermic injections of atropine and morphine have failed sadly in many cases. Subcutaneous injections of large quantities of salt and water with some soda, and large rectal injections of tannin and laudanum have been very successful in Italy. If there is plenty of acid gastric juice in the stomach, the cholera poison and microbes may be swallowed with impunity. The worst cases of cholera are produced by drinking large quantities of cholera-contaminated water, when the stomach is empty and alkaline. I think it probable that large quantities, as much as the thirst requires, of a weak acid water, will prove very beneficial in cholera. Water slightly acidulated with sulphuric, nitric or muriatic acid will probably be the best, but it is hoped that phosphoric, acetic and lactic acids will prove equally good. Lemon juice and vinegar are merely acetates and citrates of potash, and are not as good.

Shortening the Round Ligaments for Uterine Displacements—*Dr. Reid* reports three cases (*Brit. Med. Jour.*) One had suffered for ten years from excessive leucorrhœa, with a uterus much hypertrophied and retroflexed. All kinds of treatment had been used, but no permanent relief obtained. The author then performed the Alexander Adams operation. The pubes being shaved and washed with carbolic acid, an incision was made under the spray on the left side, from the pubic spine upwards and outwards for two inches, and carried down to the tendon of the external oblique muscle. The external abdominal ring was next felt, and the tissues coming out of it were gathered up by an aneurism-needle. They were then grasped by a pair of broad-pointed dressing forceps, and freed from the surrounding tissues by means of a scalpel, when by continual pulling they very gradually came out until the firm round ligament appeared. The same procedure was repeated in the opposite side. A sound was then passed into the uterus, and the ligaments were pulled upon until they fixed the womb in its natural position. Fully two inches were found drawn out on each side. Three strong chromicised catgut stitches were passed through the pillars of the ring, each transfixing the cord. To take the strain off the ligaments a pessary was introduced, and a dressing of gauze and cotton-wool applied. The patient was dismissed from hospital 26 days after the operation, and continued much improved in health when seen some months later. Two other cases are reported, both of which were much improved by the operation. The author concludes by remarking that from the results of his three cases he cannot promise much in the way of certain and immediate relief from this operation. It remedies the position but not the condition of the uterus. The cases in which it is justifiable are those which continue to be obstinate to other modes of treatment, and in which there is a hope that by remedying the malposition the discordent condition may be more readily subdued.—*Lond. Med. Record.*

Laparotomy for Perforation of the Stomach and Intestine.—According to Miculicz, of Cracow, (*Centralbl. f. Chirurg.* No. 45, 1884) laparotomy is urgently indicated in any case of perforation of the stomach or intestine, due either to direct or indirect violence, or to some pathological process. Existing peritonitis should not stand in the way of the operation, as it may be thus effectually treated. The main contra-indication of laparotomy in such cases is extreme exhaustion. In the first of his reported cases, the author of this paper had to deal with perityphlitis, which, after a time, became complicated with constipation, vomiting, and other symptoms of intestinal obstruction. Laparotomy was performed, and an incision six inches in length made in the linea alba. The abdominal cavity contained about two pints of very fetid fluid. The intestine, though bound down by numerous adhesions, showed no signs of any disturbance in the circulation. The patient died five days after the operation, and in *p. m.* examination the seat of perforation in the intestine was first discovered. The second case was a young man who, after having suffered from diarrhœa during six weeks, became constipated during the seventh week, and presented symptoms of ileus. The case was diagnosed as one of volvulus. On the

performance of laparotomy one pint of turbid serous fluid was found in the abdominal cavity. A volvulus was found, and the obstruction removed. The patient recovered from the more direct effects of the operation, but after an interval of a few weeks, succumbed to intercurrent pneumonia. The patient in the third case was a young man who, having been disturbed during sleep, and having suddenly sprung out of bed, was seized with intense pains in the umbilical region, and presented symptoms of obstruction. Sixty hours after the onset of these symptoms the patient came under the care of Prof. Miculicz, who diagnosed internal incarceration, and at once performed laparotomy. In the abdominal cavity he found about a pint of thin, badly-smelling pus and some undigested pieces of potato. On the left side, just above the brim of the pelvis, a perforation, six millimetres in length and four in breadth, was observed in a knuckle of the ileum. The mesenteric glands were much swollen, and as no other cause of the lesion could be determined, Prof. Miculicz came to the conclusion that this case was one of perforating ulcer from typhoid fever. The edges were refreshed and brought together in the long axis of the opening by a dozen sutures of silk. The subsequent course of the case was satisfactory, although the abdominal wound opened up and gave exit to a considerable quantity of pus. In the fourth case laparotomy was performed for rupture of the stomach. The opening existed near the diaphragm in the smaller curvature. The patient, whose stomach had been much distended, and whose abdominal cavity was filled with portions of food, died three hours after the operation. —*Lond. Med. Record*, Feb.

Scrofulous Neck.—The chronic enlargement of the glands of the neck, known as scrofulous neck, is secondary to irritation in the associated mucous membranes and absorption therefrom; the chief of these being the mouth and throat and the next in order the nasal, aural and ocular surfaces; and sometimes from irritation upon the skin of the face and head. A residence at Margate, together with careful dieting and nursing, is the best means of cure for these cases when they are not far advanced. The cautious use of mercury, such as the solution of the bichloride with the tincture of iron, is very good unless the inborn frailty be very marked; and iodides with iron are likewise valuable.

External applications should be used with caution. So soon, however, as the glands become adherent, either to each other or to the surrounding tissues, then it is most desirable to call in the surgeon and to extirpate every caseous gland or portion of a gland. Mr. Teale has devoted much time and has had great experience in operating on these cases, and it is due to the combined exertions of Dr. Allbutt and Mr. Teale that numerous cases have been restored from a state of misery to enjoy a life of comparatively good health. The scar remaining after the operation is small and after a year or two not very noticeable, provided the drainage be not kept up too long; it is better to risk a second operation than to keep the drainage-tube in for too long a period.—*Dr. Clifford Allbutt, Med. Times and Gazette*, and *Lond. Med. Rec.*

Trephining the Frontal Sinuses for Catarrhal Diseases.—Catarrh of the mucous membrane of the frontal sinuses is accompanied by symptoms that indicate distinctly its character, one often so severe as to call urgently for a remedy and are curable by trephining. It—in the author's experience—has no special connection with catarrh of the Schneiderian membrane either in the form of acute coryza or chronic inflammation. The symptoms are uneasiness and pain in the frontal region and a discharge of pus from the nostrils, not abundant nor continuous but an occasional escape of small quantities of thick pus. No swelling or discoloration is discoverable over the site of the sinuses but firm pressure elicits tenderness. The patient usually complains of much discomfort, and is rendered miserable by the consciousness of continued distress. These symptoms are due to *retention* and are such as are found in empyema of the antrum. A free cut being needed and as there is no possibility of introducing a probe into the frontal sinuses from below, the only expedient is to open these sinuses from the brow, ensure the patency of the opening into the nose and apply such measures as seem called for to the mucous membrane lining the interior of the cavities. In the operation a single vertical incision, 1½ inch in length, is made down to the line over the nasal eminence

of the frontal bone. The periosteum having been divided and pushed back, a trephine crown, of the size of a sixty-penny piece is applied on the middle line. The exposed mucous membrane is now incised and is found to be thickened and granular, and to inclose mucus, pus or muco-pus. The orifice leading to the nose is now dilated and a drainage-tube of the size of a crow-quill, or even larger, is pushed down so as to emerge at the nostrils while its upper end is left in the cavity. Of late the author has not trusted to drainage alone but has removed with a sharp spoon or curette the diseased mucous membrane and cauterized such soft parts as remained by brushing out the sinuses with a strong solution of chloride of zinc. The upper end of the drainage-tube lies in the sinuses and does not emerge on the brow. The skin-wound is then closed over the sinuses and unites by first intention.—*Prof. Ogston, of Aberdeen, in Med. Chronicle, and Lond. Med. Rec.*

KINNIER: REMARKS ON OTORRHEA IN CHILDREN. (*Amer. Jour. of Obstetrics*, November.)—Purulent discharge from the ear is one of the most common symptoms of aural disease. Otorrhea comes on gradually with little pain, and although the smell from the discharge is sometimes very offensive, it is frequently allowed to continue for months. As one of the causes of otorrhea we may mention catarrhal condition of the meatus and tympanum, in which inflammation may spread to the mastoid cells, and finally the brain. The prominent symptoms are rigors, tongue very furred, rapid pulse, increase of temperature, and pain and swelling of the parts around the ear, which parts assume an erysipelatous appearance. The history of an illustrative case is given in which a stumous child, aged six years, had an inflammation of the meatus and tympanum of left ear, which spread to the mastoid region, producing an abscess. This was repeated several times, when finally a polypus was discovered in the meatus, which was removed by the wire-snare. Eventually there was recovery in the mastoid region, but the membrana tympani was perforated, and hearing destroyed. Many cases of mastoid inflammation ought not to go on to suppuration if properly treated. The plan of treatment adopted on detecting pain or tenderness over the mastoid region and around the ear is, first to paint a strong solution of nitrate of silver (ʒss to ʒj) or several layers of equal parts of tincture iodi and lini iodi, or with pot. iodi cum sapone, having previously applied leeches if much swelling and redness exist, and subsequently follow up the treatment with warm fomentations or poultices containing a little opium. As regards the treatment of otorrhea by dry powders, the plan adopted is to cleanse and dry the ear well with a piece of cotton-wool twisted upon the end of a grooved ear probe, then with an insufflator introduce into the meatus whatever powder seems suitable for the case; a small quantity of cotton-wool is then lightly placed in the meatus to prevent the powder falling out. This treatment is renewed night and morning. The practice of stuffing the meatus with various powerful astringent powders, pushing the powder firmly in by means of some small instrument, and then closely packing with cotton, cannot be free from danger. The various powders used are boracic, tannic, and gallic acid, alum, iron-alum, copper, lead, zinc, and so forth. If the wet treatment is preferred, the various astringents may be used; boracic acid in the proportion of one drachm of the acid to an ounce of rectified spirit makes a very nice lotion, or carbolic acid and sulphate of zinc, four grains of each to an ounce of water, or a saturated solution of boracic acid in hot glycerine, or glycerite of tannic acid. The following are a few good lotions:

℞—Acid. carbol., gr. iv.
Sodæ bicarb, gr. xij.
Sodæ bibor., gr. xij.
Glycerine, ʒss.
Aquæ, q. s. ad. ℥ i.
Ft. lot. ad aurem.

℞—Zinc oxide.
Bismuth oxid., āā gr. v.
Glycerine, ʒss.
Aquæ, ad. ℥ i.

In connection with above treatment great benefit will be obtained by the use of the Politzer bag.—*Archives of Pediatrics.*

OIL OF WINTERGREEN IN RHEUMATISM.—Dr. Seelye reports results of treatment in 118 cases of rheumatism with oil of gaultheria, in the New York *Medical Journal*. He says the medicine may be given in capsules alone or with salicylate of sodium or

in soda water. The most common method used in acute cases was by the following formula:

℞	Ol. Gaultheriæ	♏xx
	Glycerine	
	Aq.	aa ℥i

d Give this dose every two hours during ay, and every three hours during night. e By this treatment pain and swelling gen- i erally left joints in twenty-four hours. Be- ore, or by this time the patient would generally complain of some ringing in the ears and deafness, similar to that produced by large doses of quinine, but probably not so marked. The dose was then diminished, and only one drachm given every three or four hours. The symptoms caused by the remedy were more severe in those accustomed to alcoholic liquors—delirium sometimes supervening.

The treatment, it is claimed, will speedily cure in 85 per cent. of cases; and, by actual comparison, has been found more efficacious than that with the sodium salicylate.

Lesions of the Nervous System Etiologically Related to Cutaneous Disease.—Dr. Crocker, in an article in the recent number of *Brain*, gives the result of an investigation of the published records of a large number of cases in whom nerve lesions were followed by lesions of the skin. Among others he mentions three cases—two related by Schwuminer and one by Dr. Meyer, of Strasbourg—in whom bullous eruptions were caused by a sclerosed condition of the columns of Gall. In these cases detailed histories were given, and the post-mortem examinations were carefully made—a circumstance which gives them greater weight. Dr. Crocker concludes his article with the following statements, the results of his investigation:

"(1). That less serious consequences ensue from cutting off nervous supply than from irritant or inflammatory lesions of the parts of the nervous system that affect the skin.

"(2.) That the kind of eruption produced by the nervous system varies greatly, often without any evident reason, when the nervous defect is apparently the same in place and kind.

"(3.) That the same eruption may owe its origin to any defective link in the nervous chain from the centre to the periphery.

"(4.) That the same kind of nervous lesion that at one time appears to excite an eruption or other nutritive defect in the skin, even more frequently produces no change in the skin whatever."—*Can. Pract.*

Cocaine in Dermatology.—*Dr. E. L. Keyes*, of New York, (*Jour. of Cutan. and Vener. Dis.*, Jan.) gives the results of some trial of this agent in 4 p. c. sol. The sensitiveness of the anterior urethra may be so deadened by injecting 10 m, by a deep syringe that instrumental manipulation is much better tolerated. Meatrotomy may be performed almost without pain in some cases. Small tumors may be cut out from the skin and subcutaneous tumors removed almost without pain. He removed a small syphilis chancre from the dorsum of the penis of a physician after injecting 4 m. directly under the sore, picking up the sore and surrounding integument with toothed forceps, and cutting off with scissors, then applying a ligature and three catgut sutures. The patient looked on smiling, and said he experienced not the slightest pain. He also removed a small epithelioma from the margin of the anus after injecting five minims on each side of the ulcer. Although the stretching of the sphincter with a three bladed dilating speculum caused considerable pain, the subsequent cutting little or none. He has also removed warts, moles and lipomata with a uniform testimony from the patients that the pain was not worth mentioning. Only the surface sensibility seems to be modified by the agent.

Influence of Alcohol in Relation to Voice Use.—*Dr. Lennox Browne* read a paper before the Society for the Study and Cure of Inebriety on the above subject, presenting an abstract of the testimony of nearly 400 vocalists; 101 were total abstainers and many of these were the chief cathedral singers, 65 only took stimulants at meals, 65 only took them at supper, 47 both at meals and supper, while the remaining took stimulants whenever they felt inclined and an opportunity offered; 75 per cent. never took stimulants immediately before singing, while 20 per cent. occasionally did so. Arguing from these figures, Dr. B. was of opinion that alcohol is by no means necessary; in fact the habitual use of it only tended to render the voice husky and indistinct.—*Sanitary Engineer.*

Salvia Officinalis (Sage Tea) in Catarrhal Rhinitis.—In a case of chronic catarrhal rhinitis accompanied by profuse purulent discharges mingled with dark scales, and in which the integument covering the nose and the adjoining sides of the face were red and swollen, after exhausting in vain every known remedy, the disease yielded to douches of sage tea. The patient, a married lady, had suffered from the disease for over four months. In cases of ordinary nasal catarrh, when uncomplicated by the usual post-nasal hypertrophy of tissue, infusions of salvia prove very comforting washes.—*D. Hayes Agnew*, in *Ther. Gaz.*, Jan.

The Seventy-Eighth Annual Commencement of the University of Maryland, School of Medicine, was held at the Academy of Medicine, in this city, on Tuesday, March 17th, 1885, at 12 o'clock M. The degree of M. D. was conferred upon 74 graduates and that of D. D. S. on 34 graduates in the Department of Dental Surgery. The address to the graduating class was delivered by Prof. R. Dorsey Coale, Ph. D.

Prizes were conferred as follows:

Gold Prize, to Samuel Schwalbe, of Hungary.

Miltenberger Prize, to Harry M. Thomas, of Maryland, and Edward Povall Turner, of Virginia.

Chisolm Prize, to S. Latimer Phillips, of Virginia.

Surgical Prize, to George Y. Everhart, of Maryland.

Aloes.—A high temperature converts some of its active principles into insoluble and inert substances. Esspecially it decomposes aloin, which forms from fifty to eighty per cent. of aloes. Carbonate of potash assists in the solution of the resin of aloes, and it is well to follow aloetic pills by small doses of liquor potassæ, given in aniseed-water. Some physicians give a dose of potash both before and after the aloes to develop all its powers, which it does without increasing its tendency to gripe. Gum ammoniac with aloes is said to be a better combination than myrrh. In constipation with anæmia and debility there is no better combination than one or two grains of aloes, with an equal quantity of dried sulphate of iron. A favorite prescription with many is: Tinct. aloes socot., U. S. P., ℥j.; aq. anisi, ℥ iiss.; liquor potassæ, ʒ ij.; ol. anisi, gutt. x. Dose, ʒ j. to iv. Sometimes the excellent and pleasant liquor ammoniæ anisati of the Germans is better.—*Med. Record.*

A Test for Albumen in the Urine.—Dr. Kemper writes to the *Medical Record:* "Take a solution of salt and vinegar in a test-tube, heat over a lamp, then overlie the solution with one drop of the suspected urine, and if albumen be present, it will plainly be seen by the appearance of a coagulum on the test solution. If no coagulum appear, albumen is not present. This test is given by Professor J. North as a modification of the acidulated brine test."

Caffein in Heart Disease.—Riegel,* after extended trial of this remedy and its preparation, formulates his conclusions as follows:

(1) Caffein is a heart regulator and diuretic in the same sense that digitalis is.

(2) Caffein in suitable dose and form increases the power of the heart, slows its action, and increases arterial tension, producing this effect soon after its administration.

(3) Caffein acts rapidly as a diuretic.

(4) The indications for the use of caffein are in general the same as those for the use of digitalis.

(5) Caffein is best administered in small and frequently repeated doses. In most cases one to one and a half grammes of the double salt daily is sufficient, though it is safer to begin with smaller doses.

(6) The main difference between the effect of caffein and that of digitalis is that the former is much more prompt and is not cumulative.

(7) In many cases in which digitalis fails, caffein will succeed.

(8) It is not advisable to give morphia at the same time with caffein; the latter, in that it restores the failing compensation, is practically a narcotic in these cases.

(9) Caffein, and especially its soluble double salts, sodio-caffein benzoate, salicylate, and cinnamylate, the solubility of which favors their subcutaneous use also, are, as a rule, better borne than is digitalis.

*Verhandlungen des Congresses für Innere Medicin, 1884. Fortschritte der Medicin, 1884, September 15.

Beecher's† results are not materially different from those of Riegel. Diuresis goes hand in hand with the tonic effect of the drug upon the heart, and this observer also found that caffein succeeds sometimes when digitalis fails. He does not seem to have used the double salts, but thinks that of the more common preparations the hydrobromate is less likely to make the patient wakeful.—*Boston Med. and Surg. Journ.*

Medical Items.

Among the appropriations by the late Congress are those giving $15,000 for the care of non-resident sick poor in the Providence Hospital, $7,500 for the Garfield Hospital, $15,000 for the Columbia Lying-in Hospital, $5,000 for the Children's Hospital, $15,000 for the erection of a homœopathic hospital, and $40 a month, each, for the physicians to the poor. The National Board of Health gets $5,000, and the Senate struck out from the Sundry Civil Bill the provision doing away with the board, and authorized the payment of the expenses incurred by it last year.—*N. Y. Med. Journ.*

The Medical Department of the University of New York, at its commencement held March 10th, conferred the degree of Doctor of Medicine upon one hundred and seventy-five candidates.

The Thirty-third Annual Commencement of the Maryland College of Pharmacy was held at the Academy of Music on March 19th.

Charity Hospital Library, New Orleans, has 2,127 bound volumes and 375 unbound periodicals. The former for the most part of old date.

A saturated solution of hydrochlorate of cocaine in nitric acid is said to make a painless caustic.—*Louisville Med. News.*

Dr. F. J. Crawford, a prominent physician of Carroll Co., Md., died at his residence on March 18, in the 67th year of his age.

General Grant's physician, Dr. Douglass, reports, March 18th, that "there has been no increase of the throat difficulty in the last three days. It seems to have been arrested."

†Wiener Med. Blätter, 1884, No. 21. Fortschritte der Medicin, 1884, September 15.

A petition has been in circulation, we learn from the *N. Y. Med. Journ.*, praying for the appointment of Dr. A. N. Bell, of New York, editor of the *Sanitarian*, as Surgeon-General of the Marine Hospital Service, to supersede the present efficient incumbent, Dr. John B. Hamilton, who has held the office since the death of Dr. J. M. Woodworth.

The sanitary Council, of the Mississippi Valley, at its recent meeting in New Orleans, adopted a resolution asking the boards of health represented in the Council to suggest the manner in which they think the money appropriated by Congress ($340,000) to be used at the discretion of the President, should be applied.

During the past two weeks 246 students of medicine have been graduated from the medical schools of this city.

A recent commencement orator gave to the graduates three strands to weave into the rope of prosperity—mastery of their art, the character and bearing of a gentleman, and common sense.

The profession in Massachusetts, with Dr. H. O. Marcy as leader, has taken steps looking to the establishment of a Board of Medical Examiners in that State.

Dilute sulphuric acid in some skin diseases, such as lichen, prurigo, chronic nettle-rash, is successful in relieving the distressing itching, formication, and tingling of the skin. It is applied locally and given internally in ten minim doses. The mouth should be rinsed with a weak alkaline wash after each dose.—*Med. Rec.*

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from March 10, 1885, to March 16, 1885.

Army Medical Board to meet in New York City, April 6, 1885. Detail for Board: Lt. Col. Jos. B. Brown, Surg.; Maj. Anthony Heger, Surg.; Maj. Jno. H. Janeway, Surg.

Surg. Heger to be relieved from duty in Dep. East, and Surg. Janeway to perform duties on the Board in addition to his present duties.

Taylor, Blair D., Capt. and Surg. Leave of absence extended two months.

Original Article.

THE USE OF THE OPHTHALMOSCOPE IN THE DIAGNOSIS OF BRAIN DISEASE.*

BY W. FRANKLIN COLEMAN, M.D., M.R.C.S., ENG.

Professor of Diseases of the Eye and Ear at the Baltimore Polyclinic and Post-Graduate Medical School, Formerly Surgeon to the Toronto (Ont.) Eye and Ear Infirmary, and Ophthalmic and Aural Surgeon to the St. John (Canada) Public Hospital.

Mr. President and Gentlemen: Our knowledge of the physiology and pathology of the central nervous system is so limited, the diagnosis of brain lesions so difficult, the well-known condition of the eye in those lesions so unmentioned or dubiously mentioned by the text-books on medicine, as to afford me some excuse for urging the claims of the ophthalmoscope in the study of the intra-ocular end of a brain nerve, during its structural changes which are connected with intra-cranial disease. While the subject embraces a limited personal experience, I freely admit the testimony of such authorities as Drs. Allbut, Jackson, Gowers, Mr. Nettleship, and, incidently, several others.

While the nature of many diseases within the chest and abdomen is revealed to touch and the ear, the maladies of that most inaccessible part of the body—the cranium—give out no certain sound, and will not disclose themselves to any wizard touch; so it remained for the genius of Von Graefe and Sichel, the patient skilful labors of Saemisch, Liebreich, Schweigger, Sœlberg, Wells, Jackson, Allbut, Gowers, and others, to illuminate with the ophthalmoscope the dawning light, through which men were eagerly striving to discover the nature and situation of intra-cranial disease.

The popular idea that the oculist has, and perchance *needs*, no knowledge of general medicine to successfully treat the eye, is no less false than the, I fear, professional belief that the general practitioner can gain little from the ophthalmoscope. With the herculean task of gaining a fair knowledge of the structure, working, derangement, and repair of the general system, it is not to be expected that even a Hercules could also keep abreast of the information and experience in regard to any special organ. Yet, since the whole is made up of all its parts, and the parts are interdependent and dependent upon the whole, any approach to a comprehension of the whole organic system must involve some familiarity with every part. No more striking illustration of this can be cited than the evidence of cerebral lesions that may be elicited by an ophthalmoscopic examination of the intra-ocular end of the optic nerve, called the optic disc or papilla. In the pre-ophthalmoscopic period (prior to the great invention of Helmholtz in 1851) there certainly had been *something* done to trace in atrophy of the optic nerve the connection between amaurosis and brain disease, but a meningeal inflammation propagating itself along the optic nerve as a *descending neuritis* had not been thought of, and the cause is not far to seek, for in brain disease, accompanied by very considerable optic neuritis, the sight may be perfect, hence disease of the optic nerve was unsuspected. It thus happens that many patients having symptoms of brain disease, accompanied by lesions of the optic nerve, have, on account of perfect vision, no disposition to consult an *oculist*, and while so few men in *general practice* use the ophthalmoscope, one most unequivocal sign of encephalic disease, viz.; optic neuritis, is frequently overlooked. As the optic papilla is the chief intra-ocular part concerned, and furnishes the most palpable and constant information in intra-cranial disease, allow me to remind you of the anatomy of the optic nerves. Under the name of the optic tracts, they take their origin just in front of the cerebellum, in the tubercula quadrigemina or optic lobe, to which visual perception is attributed, also in the corpora geniculata; they then pass forward along the under surfaces of the crura cerebri, taking on their way some fibres of origin from the optic thalami and reaching the olivary process of the sphenoid, just under the floor of the third ventricle, unite to form the optic commissure or chiasma. As the optic nerves pass forward from the chiasma they receive at the optic foramina a loose sheath, from the dura mater, which becomes lost in the sclera. The nerve is about three millimetres in diameter before it perforates the cribriform plate of the sclera, and contracts to two at its intra-ocular end, where it spreads out to form the internal layer of the retina. The nerve is also invested by a second close fitting inner

*Read before the Clinical Society of Maryland, March 20th, 1885.

sheath, which is continuous with the pia mater, and sends processes between the nervules of the optic bundle. Between this inner and outer sheath is the vaginal space of Schwalbe, which is continuous posteriorly with the arachnoid space of the brain, and anteriorly within the posterior part of the sclerotic opening, is, by some, said to be continuous with lymphatic spaces in the substance of the optic nerve, by others to be closed. Evidently the vaginal space may become distended by subarachnoid fluid, for there is *not* a reflection of the arachnoid at the optic foramen to prevent it.

The appearance of the optic disc, the first time I discovered it with the eye mirror and a 2½ inch lens, struck me as resembling a diminutive cream rose full *moon*, about the size of a large split pea, rising in a pink sky of surrounding choroid, which, by its contrasting color, gives a well-developed sharp border to the disc.

The changes in the disc produced by cerebral diseases are *congestion*, *inflammation*, and *atrophy*. The congestion of the disc may be a simple hyperæmia; if attended by œdema, it is the stauungs papilla of Von Graefe; the "choked disc" of Allbut, or congestion papilla. In intra-ocular neuritis, or papillitis, the papilla alone may be affected; in other cases the neuritis occupies the length of the optic nerves, as has been shown in autopsies by Allbut, Gowers, Hulke, Virchow, etc. Atrophy of the disc may be primary or simple, or consecutive, as a consequence of papillitis. Authorities are in accord as to the great *frequency* of *optic neuritis* in intra-cranial disease. Annuske and Reich collected 88 cases of intra-cranial growths with ophthalmoscopic examinations and autopsies, and found ophthalmic changes in 75 per cent. By common consent, the most frequent cause of optic neuritis is intra-cranial tumor; next to it, meningitis. Cerebral abscess and softening are occasional causes, and hemorrhage a very rare one. Tumor is nearly always attended by optic neuritis, (Hughlings Jackson). Allbut writes, "My own opinion certainly is that changes, either of a congestive, neuritic, or atrophic character, may be found in the discs, at some time or other, in the course of almost all cases of intra-cranial tumor." "From my own experience (Gowers), I should say that neuritis occurs in about four-fifths of the cases of intra-cranial growths," Encephalic disease may also manifest itself through paresis or paralysis of the ocular muscles, producing squint and double vision. That optic neuritis may possess diagnostic significance of brain-lesion, the extra-cranial causes which produce, or are associated with, neuritis must be borne in mind, such as albuminuria, tobacco, alcohol and lead poisoning, the exanthemata, suppression of the menses, pernicious anæmia, loss of blood, exhausting diseases, neuralgia of fifth nerve, in rare cases secondary syphilis (Nettleship), and tumors in the orbit. It may occur idiopathically without obvious cause (Gowers). Simple *congestion* or *hyperæmia* of the papilla very commonly precedes atrophy. It is sometimes the expression of a state of congestion and degeneration of the whole optic nerve, but sometimes apparently limited to the disc (Gowers). It frequently is the first stage of tobacco amaurosis, the last being atrophy.

"Choked disc," or *hyperæmia with œdema*, is the first stage of neuritis, and frequently associated with it. Its principle causes are said to be the same as produce neuritis, viz.: tumors, meningitis and hydrocephalus. Primary atrophy of the disc is more frequently associated with locomotor-ataxia than with any other disease. Often I have seen it occur without assignable cause, and once, from a blow on the eye.

Galezowski gives a table of 166 cases embracing the causes of primary and consecutive atrophy:

Cerebral causes	40
Locomotor-Ataxia	33
Traumatic	22
Alcoholism	13
Syphilis	12
Other causes	46
	166

Allbut is of opinion that primary atrophy is generally due to mischief at the base, (tumor), or to ventricular dropsy, which may compress and sever the nerves or tracts at some point in their course. From the evidence of Messrs. Critchett, Wordsworth, and Hutchinson, and others, and my own experience, I think that tobacco in excess will produce atrophy of the discs, though some deny it. To be able to distingush between a normal and the inception of a pathological appearance of the papilla, much experience is required, and the at-

tempt will soon prove the saying, "Pathology is but the shady side of physiology." A full-blown neuritis may be quite palpable to an amateur ophthalmoscopist, while an expert may be unable to decide as to a slight hyperæmia, or say whether a disc is pale from incipient atrophy or simple decoloration. *The* indication of hyperæmia is an abnormal redness, which has a tendency to blur the edge of the disc. Comparing the discs may give some help, and noting whether the redness increases from time to time. The signs of neuritis and choked disc are similar, and vary with the stage. In the first stage the disc is slightly swollen and red, and the edge, though blurred, may be still distinguished; while, in intense papillitis, the color of the disc is so blended with that of the surrounding choroid, that it can be frequently distinguished only at the point of convergence of the retinal vessels. Impairment, or loss of sight, is the chief symptom in intense neuritis, though there may be marked neuritis without any impairment of sight. Pain in the eye is rare; vision usually begins to fail first in one eye, and sight may fail completely in a few days, or decrease very slowly. Restriction of the visual field is common, and color-vision is frequently defective. The neuritis of tumor is double, rarely unilateral, and, it appears, is usually a late production of tumor. Dr. Jackson has pointed out that the neuritis often coincides in its onset with an obvious increase in the other symptoms of the cerebral tumor. He recorded one case, in which a man had had symptoms of cerebral tumor for nine years; during the last three years, his discs had been repeatedly examined and found normal; six weeks before death neuritis was discovered.

The signs of *atrophy* are pallor, and, later, depression of the disc, with shrinking or absence of the capillaries. When the atrophy is marked, there is diminished vision, nearly always more considerable in one eye than the other. There is a concentric irregular marginal limitation of the field of vision. Frequently there is defect of color-vision.

The relation of papillitis to intra-cranial disease is still a vexed question. I shall refer briefly to the principle theories. Von Graefe gave the first in 1859. He distinguished two cases. In one, the change in the disc (neuritis) was slight, with a tendency to invade the adjacent retina. In this case there was meningitis, and inflammation of the nerve trunk was found by Virchow, which inflammation was assumed to have been communicated to the optic nerve from the inflamed meninges, and to have descended the nerve to the eye. This Von Graefe designated "descending neuritis." In other cases of considerable swelling, hemorrhages, and vascular distension of the papilla, (stauungs papilla), accompanied by cerebral tumor, no signs of inflammation were perceptible on naked eye examination of the trunk of the optic nerve. This condition of the papilla he attributed to increased intra-cranial pressure, which obstructed the return of blood from the eye through the ophthalmic vein by compressing the cavernous sinus.

The theories of Schmidt and Manz are largely accepted in Germany. Manz showed that distension of the vaginal space around the optic nerve is frequent in neuritis, and believed the distension to be due to intra-cranial pressure or increase of subarachnoid fluid. Further, he found that injections into the subarachnoid space of animals passed into the sheath and caused fulness of the retinal veins, and in some cases transient redness and swelling of the papilla. Schmidt demonstrated that a colored liquid injected into the sheath passed into the lymph space of the nerve at the lamina cribrosa, and suggested that neuritis is produced by the irritation of the liquid passed into the lymph spaces.

A theory was put forward by Schmidt, in 1860, extended by Dr. Hughlings Jackson in 1863, supported by Brown-Sequard, and was formulated by Benedikt in 1868. It assumes that the tumor acts as a source of irritation, which has a reflex influence through the vaso-motor nerve upon the optic disc leading to its inflammation. Of these theories, that which accounts for changes in the disc by inflammation of the meninges propagated along the nerve trunk, appears the best supported by the frequent determination upon *post-mortem* and microscopical examinations of the condition upon which the theory is based. Although neuritis may occur in tumor of any size or kind, in any part of the brain, it is rare in tumor of the convexity, while it is common in that of the base and most common in that of the anterior lobes (Russell Reynolds). Again, *meningitis*, limited to the

convexity, is *seldom* accompanied by intra-ocular changes, while *basilar* meningitis is *usually* attended by neuritis. In many cases of tumor a local meningitis in the vicinity of the growth and accompanied by inflammation of the optic tract has been found. Now the proximity of this *inflammation* of the basilar meninges (whether independent or the result of tumor) to the optic tracts makes its communication to the tracts highly probable, and the fact of the so common association of inflammation of the meninges and tract increases the high probability to a seeming certainty.

A case of Mr. Hutchinson's in which no distension of the retinal veins was produced, although the cavernous sinus was completely obliterated by the pressure of an aneurism, seems to go far towards destroying the theory of obstructed blood return from the eye by pressure on the sinus. The vaso-motor theory is rejected by Leber and a numerous following, on the ground that "it involves a mechanism not known to exist, and a complex relation of the optic nerve to all parts of the brain difficult to conceive."

In conclusion I have selected notes of some hastily reported cases in illustration.

Mary L., æt. 20, single, was admitted into the St, John (N. B.) Gen. Pub. Hospital, July 19th, 1878, with both eyes "*stone*" *blind.* The blindness of the right eye came on suddenly three weeks previously and was preceded during the day by severe pain in the brow, which has kept her awake most of the time since. Two days before admission she lost the sight of the left eye in a similar manner to the right. Patient very nervous with slight choreic movements of the arms. A year earlier had during three weeks constant pain in the top of the head and vomited three to four times daily.

Denies syphilis, but two ulcers on the calf of the leg have all the characters of specific sores. Has no perception of light. Pupils react very imperfectly.

The eyes at rest both look to the left. When the right eye fixes for a near point the left diverges. There is white atrophy of both optic discs and probably cerebral syphilis at the base involving optic nerves.

℞. K. I. grs. x, Tr. cinchonæ ℥i t. i. d.

Aug. 8th.* ℞. Hyd. perchlor. gr. $\frac{1}{12}$, Ammoniæ mur. grs. v, Tr. nucis vom. m. x. t. i. d. Discontinue K. I.

Aug. 20th. ℞. Ung. hydrarg. ℥ss. Rub into axilla and thigh on alternate days. ℞. Pil. hydrarg. grs. ii b. d.

Oct. 12th. *No ptyalism.* ℞. K. I. grs. v, Sp. am. aromat. ℥i, Tr. cinch. ℥i t. i. d. Stop other medication.

Oct. 22nd. Mouth very sore and marked mercurial fetor. Discontinue potass. iod. ℞. Potass. chlor.

Nov. 7th. No light perception with R. eye. Left eye can count fingers at thirteen inches. ℞. Potass. iod. grs. x, t. i. d.

April 9th, 1879. For the past three and a half months Strych. sulph. has been given hypodermically from gr. 1-24 to gr. 1-8 then reduced to gr. 1-16 b. d.

Has had tenotomy of the right internal and left internal recti muscles.

The choreic movements and headache have disappeared. Direction of eyes much improved, but they still look slightly to the left.

The right eye now distinguishes light and the left reads *No* 200 *at* 12 *feet.* Discharged.

Case II.—J. B. H., æt. 53, admitted into the St. John Hospital (general ward), July 5th, 1881. He is a muscular looking man, 4 feet 10 inches high. Weighs about 130 pounds. Says for the past year he has had a very dizzy head, and would fall any day in the road, but would soon be able to rise again and walk on. The fall was always preceded by giddiness. Six months ago he began to vomit about every second day, and soon after vomited every morning, if he laid in bed until 7 o'clock. When he rose earlier the vomiting did not come on. This continued up to last week; since then he has not vomited. During the past month has had a pretty severe pain from the forehead to the back of the head, lasting an hour or two every day, and has been unable to see to read. Memory failing for past year. Pulse 68, small and rather weak; skin normal temp. to touch; appetite good; bowels costive; sleeps well; whistles feebly; grasp of hand weak; flexion of forearm and legs strong; gait very unsteady, and he seems in constant danger of falling; patellar reflex normal; no lightning pains; urine normal; right ear hears the watch only at ½ inch; ordinary loud voice at ten feet; left ear hears the watch only at contact or ordinary voice at four feet; speech (broken Dutch-English) probably normal;

*Sees position of window with right eye. No perception of light with left eye.

smell normal; pupils slightly dilated by atropine; vision, right eye counts fingers two feet; vision left eye, counts fingers twelve feet. Ophthalmoscopic examination shows intense optic neuritis with hemorrhages, and infiltration of retina and disc. There is probably tumor of the cerebellum involving the tubercular quadri gemmina.

June 25th. The left pupil a little small, reacts imperfectly to light. Right pupil half the size of left, and reacts very imperfectly; percussion on the temples hurts a little, on the forehead less; head twenty-four inches in circumference.

July 15th. Last evening and this morning refused to take his medicine, saying there was something in it to poison him. July 24th. The patient was discharged at his own request.

Case III.—Sarah B, æt. 36, admitted into St. John Hospital February 9th, 1881. First noticed two months ago that the left eye was so blind it could not see daylight. The right eye failed so much three days ago that she could not see to read

Three years ago was confined to bed six weeks with constant, severe pain in the top of the head. Was at times very chilly and again very hot and thirsty. No vomiting. The head was very hot. The pain was finally much relieved by application of iced-water to the head, but has been very severe most of the time since up to the present.

Memory is failing, and she feels stupid. Pulse 80, weak; sleeps very badly; appetite poor; no history of syphilis; mother and one brother died of phthisis. With right eye can count fingers within six inches. Left eye has no perception of light. The right optic disc normal in appearance. Advanced neuritis of the left. The atrophy probably the direct result of meningitis.

March 26th. Has been treated with potass. iod., potass. brom. and hydrarg. perchlor. and cold water to the shaved head.

The right disc normal in appearance. Discharged from Hospital relieved of pain, but vision about the same as upon entering. Returned to Hospital August 17th, 1881, with headache and nausea. The sight of the right eye began three weeks ago to get worse, and she cannot now distinguish light with either eye. Pupils large and immovable. Atrophy of *right* optic disc. Pulse 104, small and weak. ℞. Hyd. submur. gr. $\frac{1}{6}$ every hour.

Aug. 20th. Severe pain in head. ℞. Potass. iod. grs. x t. i. d.

Aug. 22nd. No pain in head. A prominence noticed over the left frontal eminence (osteoma).

Oct. 27th. Discharged with perception of light with right eye only. The headache absent for several weeks, and the frontal prominence much reduced.

Case IV.—Concussion of the brain followed by atrophy of the discs.

Rev. D. B. consulted me October 5th, 1883. Last April was thrown backwards from a buggy and fell on the back of his head. After recovering, in a few minutes, from insensibility, felt nausea. The injury did not confine him to the house. Since then has had a feeling of pressure on the front of the head, and sometimes behind the eyes. Every few nights is sleepless and has tinnitus aurium, "rain-like sounds." The sight began to fail a few days after the accident, and in a fortnight he was unable read.

Has photopsies.

Right eye, vision 1-10; left eye, vision, 1-10.

Blueish-white atrophy of both discs. ℞ Strych. sulph. gr. 1-48, t. i. d.

℞. Potass. brom., grs. xv, and repeat p. r. n. in evening.

I shall only add, if, on account of any words of mine, the ophthalmoscope shall aid you in the diagnosis of so obscure a class of diseases as those of the brain, I shall think your time not squandered, and myself amply repaid.

Albuminuria From Chloroform Inhalations.—*M. Ternier* (*Un. Med.*) has made a series of experiments with the view of deciding this question. Of ten cases which were carefully observed with reference to the presence of albumen in the urine, it was discovered in eight in which there had been no operation. The period of anæsthesia varied from thirty to seventy-five minutes. In another series of ten cases, in which surgical operations were performed, albumen was present in every instance. Whenever a slight trace of albumen had been found before the anæsthesia the amount was greatly increased after anæsthesia. (These experiments are noteworthy in connection with the opinion that chloroform is safer than ether for patients withrenal disease).—*N. Y. Med. Journ.*

Society Reports.

PROCEEDINGS OF THE MEDICAL SOCIETY, DISTRICT OF COLUMBIA.

STATED MEETING HELD JAN. 28TH, 1885.

(*Specially Reported for the Md. Med. Journ.*).

The Society met with the President, DR. W. H. TAYLOR, in the chair, DR. MCARDLE, Secretary.

Dr. J. Ford Thompson read the report of a case of

VARICOCELE.

Mr. President:—I shall very briefly report a case of varicocele upon which I operated just a year ago, for the purpose of bringing the subject properly before the Society, and then, orally, I shall refer to other cases and discuss the various methods of treatment.

A. T. B., a youth of seventeen, was brought to my office by his father in December, 1883, for examination, with the view of getting my opinion about the propriety of an operation upon his son who, he said, had suffered for some time from an enlargement of the scrotal spermatic veins. As he had been under treatment, both father and son fully understood the nature of the disease.

The young man was well-grown and appeared to be in good health, but of a rather nervous temperament. I learned from him that he first noticed elongation of the scrotum and slight enlargement of the veins about three years previously, and about the same time he was conscious of a slight feeling of discomfort in the parts. Having detected something wrong, he probably exaggerated the symptoms and, in the course of some months, a physician was consulted who advised the wearing of a suspensory bandage. This he continued to wear, off and on, up to the time of visit to me, but with a gradual increase in the severity of the symptoms.

Upon examination I found the scrotum very much elongated and the veins of the left side enormously enlarged. The left testicle was perceptibly smaller than the right, but of course, at his age, nothing satisfactory could be obtained as to the effect upon the venereal appetite. He complained very much of the "dragging" sensation in the groin, and a general feeling of discomfort which, although it did not amount to real pain, was extremely annoying, his mental suffering being, perhaps, greater than his physical. I considered it a bad case for one of his age, but hesitated about advising an immediate operation; so directed him to use the cold douche twice a day, and showed him how to apply the bandage so as to give greater support to the testicle. I expressed the opinion to the father that I thought it would eventually be necessary to operate, as the testicle showed evidence of atrophy, but that I would prefer having the case under observation for a time before deciding to perform it.

I saw the case several times during the next two months, and the patient appeared to be not at all satisfied with his condition or treatment; and, as the symptoms appeared to justify it, I determined to operate without further delay.

I had several times operated for the radical cure of varicocele, and had also several times performed Sir Astley Cooper's operation of "retrenching" the scrotum, usually with very satisfactory results; but with my faith in antiseptic surgery, I felt convinced that direct incision and ligation of the veins was the best operation. Previous to this I had always performed the subcutaneous operation with the silver wire loop with constant traction by a piece of India rubber bent so as to act as a spring. Whilst, as I have said, the results were uniformly good, the treatment was painful and never appeared to me devoid of danger. The amputation of a part of the scrotum seemed to me unscientific; and I had reason to believe that the relief afforded was very often only temporary and sometimes not even that. January 28th, 1884, with the assistance of Drs. Hagner and McArdle, I performed the following operation, which is very similar to that practiced by Annandale, of Edinburgh, and other eminent European physicians. The pubis and scrotum were shaved and then thoroughly washed with carbolic acid solution; I separated the vas deferens from the veins with my left hand and made an incision of about two inches directly over the veins in the upper part of the scrotum. The veins were at once exposed in the wound and after separating them somewhat from the surrounding tissue the vas deferens with the spermatic artery being drawn well out of the way,

I passed an artery needle, armed with a strong ligature of carbolized cat-gut, under the veins, and then cut the ligature so as to leave two in position. The tissue under the veins was then torn a little that I might separate the ligature to the extent of half an inch, when they were tied tight and the veins cut between them. The wound was washed with carbolic solution and sutured with carbolized silk. Iodoform gauze was applied and over this cotton wool; the entire scotum and region of the pubis was included in the dressing. The part was then bandaged so as to elevate the scrotum well up to the pubis, an opening being left for the penis only.

I kept a record of the pulse and temperature, but it would be of no interest as there was scarcely an appreciable rise in either after the operation. On the third day I looked at the wound and it was apparently perfectly healed. The dressing was not taken off at this examination, but the bandage merely loosened that I might get a peep at the wound from above. He had suffered no pain, and the only inconvenience incident to the operation was a retention of urine during the second and third days, necessitating the use of the catheter. On the fourth day I took off the dressing, and as the incision appeared so firmly united, I also took out the sutures. It was perfect union by first intention. I reapplied the dressing as before, and kept him in bed a few days longer, when he was allowed to get up with a nicely fitting suspensory bandage.

I had this patient under observation for several months. The knot of condensed tissue or hardened veins gradually disappeared, and four months after the operation he expressed himself perfectly cured, and there was not a trace of the disease or the operation. I have seen him several times since and he continues perfectly free from all the symptoms he had experienced for several years.

Dr. Thompson, continuing, said there were many very able advocates of the plan of treatment he had adopted in the case reported. He had seen one of the most eminent surgeons in Europe incise and dissect as he had done, using a silk ligature, however, instead of carbolized cat-gut. The most important question is as to the justifiability of the operation. When we take into consideration the prevalence of the affection and remember that one male in ten is more or less affected the magnitude of the question is apparent. Fortunately, comparatively few require such radical treatment, but still the number is great enough of those who suffer mentally and physically from this trouble. Atrophy and consequent loss of virility do not form a pleasant subject for contemplation. Various positions in life are no longer open to these suffering individuals—the Army and Navy Boards, for example, close their doors against them.

For himself, Dr. Thompson had seen enough cases to enable him to form a decided opinion on the subject. He postponed an operation as long as practicable unless the case was an extreme one demanding immediate operation. If atrophy was threatened he hesitated no longer. In other cases relief was often afforded by the use of a suspensory bandage, such a one as Morgan's, for example, by which the testicles were well drawn up on the pubis.

He performed his first operation for this disease ten years ago. The patient was a well-known business man, between 35 and 40 years of age, the father of several children. For a year past his domestic relations had been rendered unpleasant by a loss of virility. He had not been able to have any relations with his wife for more than a year. In operating on this man, Dr. Thompson used wire with an ordinary button, first carefully separating the vas deferens from the enlarged veins. The patient was confined to bed for a week and suffered a great deal of pain. Six months afterwards, he came into the doctor's office declaring in the most happy and earnest manner that he was a new man and that his power was completely restored.

Dr. Thompsom continued to perform the operation in this manner until the revival of the old operation of Sir A. Cooper, who advised retrenching the scrotum. This method then became very common, especially in this country. Dr. Thompson performed several such operations, and they gave him a great deal of trouble. In one case consecutive hemorrhage occurred, despite the fact that he had taken every precaution to prevent it. He was compelled to cut loose the sutures, and turn out enormous clots of blood, leaving the wound to heal by granulation. Afterwards in operating he left the wound open until all bleeding ceased, using liga-

tures and torsion, never, however, letting the clamp remain, as he was convinced it did more harm than good. He did not believe the operation a good one, for it is too uncertain as to its results.

In the case of a young man with an enormous scrotum, he ligated the veins subcutaneously. The patient, however, did not get entirely well until a part of the scrotum was removed several months after the first operation. In two other cases he performed the combined method. In the case reported this evening, it was not necessary to retrench the scrotum. He was fully convinced that more irritation was caused by the subcutaneous method than by direct incision. By the subcutaneous method it is impossible to include only the veins, other tissue will necessarily be grasped as the sense of sight affords no aid. It takes six or eight days for the ligatures to ulcerate through; suppuration sometimes occurs, and there is danger of phlebitis and erysipelas. With antiseptic dressings the method of direct incision is almost devoid of danger. German authorities consider the subcutaneous method a relic of the past. This opinion will be adopted by all believers in antiseptic surgery. Acupressure causes more irritation than a clean cut in a vein. When an antiseptic dressing is properly applied, and the scrotum well drawn up on the pubis, half the danger is passed. The thermometer will warn us of approaching mischief. Years ago, the speaker said, he was often in doubt as to the advice he should give in cases of varicocele. Many leading New York surgeons opposed any operation for the radical cure, and one professor stood almost alone in advocating it. In Europe the operation is performed, but in Germany very little attention is paid to varicocele. The same is true of phimosis in children. In this country the suffering is very great from both sources. He did not agree with the learned surgeon who said the operation should not be performed, for the malady did not threaten life. Indeed, it should be done more frequently than it is; not, however, in every case of varicocele.

In reply to a question as to why it should occur so much more frequently on the left side, Dr. Thompson said the reason was purely anatomical. The right spermatic vein emptied directly into the vena cava. The left passed up into the abdomen and emptied into the left renal without angle or valve. Any mechanical impediment, impaction of fæces, or a loaded sigmoid flexure of the colon, for example, will press upon the vein. Anything, in a word, that retards the return of the venous blood from the organ, aggravates, if it does not really cause varicocele. In women varicose veins of the ovary occur more frequently on the left side for the same reason.

Dr. Hagner said it was interesting to note that men of advanced age do not seem to suffer as much as young men, though in the former these tumors may be larger than in the latter. Masturbation, which is said to be a cause, may be called the sin of youth, and old men are without the mental anxiety as to their virility which haunts the young man in the condition. He believed the relief afforded the moral state was as great as the physical cure effected by the performance of this operation. We all know that there is no greater source of mental worry than some affection of the gentalia, no matter how slight.

Dr. J. B. Hamilton praised the thorough manner in which Dr. Thompson had treated the subject, and said he had left scarcely anything else to be added. It seemed to him that Doctor had made a correct statement of the best method of radical cure for this disease. That was the direct method. Unless the case was one of exaggerated charater, he was inclinded to doubt the propriety of the severe method formerly adopted. The affection did not place the patient's life in jeopardy, and the operation did, by reason of the dread of inflammation and all its consequent ills. Cutting down upon and *removing* a portion of diseased vein is a hazardous operation, despite the adoption of antiseptic methods. There can be no question as to the fact that ligation causes the least pain. He had tried acupressure, compressing the veins as firmly as possible. He doubted, though, if there is such a thing as perfect occlusion by such a procedure. Since antiseptic surgery had become the fashion, our enthusiasm has led us to forget that we ever before had union by first intention. He had recently obtained primary union in a number of cases by strict attention to cleanliness, and by taking care that every bleeding vessel was completely stopped. He thought we were too enthusiastic in our praises of the

antiseptic details. There was an error in the statement about the priority of animal ligatures, that was due to Dr. Physick.

Dr. Thompson could not permit an attack on antiseptic surgery to go unanswered. There was a time when he thought the results obtained by him were perfectly wonderful. It was after he had discarded the wet rag and placed his faith in more improved dressings. Gradually he had gotten into Listerism with all its improvements; but he found the antiseptic surgery of Germany as far ahead of Listerism as that method was of the older forms of treatment. In common with all other surgeons he had obtained union by first intention prior to his adoption of the antiseptic methods. But a man may have a dozen successful cases like Dr. Hamilton, and yet in the next dozen run the risk of tetanus, erysipelas, pyæmia, and concomitant evils. A man practicing antiseptic surgery, and taking every antiseptic precaution as Billroth does, takes no such risks. He would not say that a patient or a limb might not occasionally be lost, but it would be for reasons independent of any method of operating or dressing. On the old plan compound fractures did not heal without suppuration. Now, he fearlessly removed a tarsus, or an inch of the tibia and fibula, and did not look at the limb for a week or more. The results of antiseptic surgery have gone beyond human expectation. It is a marvel to him how any surgeon can say a word in favor of the old methods, when compared with antiseptic surgery as practised in all its details.

Dr. Hamilton took the liberty of disagreeing with the last speaker. He thought there were other methods of making a wound aseptic without being obliged to have recourse to the mummery of the so-called modern antiseptic details. He referred to Tyndall's experiments with cotton-wool, and Gamgee's use of that article as a "dry dressing" with good results. He called attention to the fact that neither Keith nor Lawson Tait practiced antiseptic surgery "in all its details." Dr. Thompson admits that when we are able to place the clean cut parts in perfect opposition, the details of antiseptic surgery are not necessary for primary union. Cannot the wounds of varicocele be so treated?

Dr. Thompson did not consider Keith and Tait surgeons. They are skilled specialists, and as far as he was aware, made no pretensions to general surgery. Moreover, the fact that some leading men in Philadelphia, New York, Dublin, or elsewhere, will not adopt methods recognized as good, indeed, as the best, by the majority of the leading men of the world, would not prove much against such methods. In reply to Dr. Smith, he said there were some operations where the antiseptic method could not be used so thoroughly as in others. In the case of harelip, for example, where the parts are brought so perfectly together, there does not exist the same necessity for antiseptic surgery as in a compound fracture of the leg. The reason many gynecological operations are not more successful, is because antiseptic surgery cannot be practised in all its details. It was not inconsistent for him to yield due credit to Keith and Tait, and in the same breath say that before the introduction of antiseptic surgery it had become dangerous to perform an ovariotomy in a German hospital. Since the introduction of this method the very atmosphere of these hospitals has improved. The constant use of antiseptics in one form or another has purified every ward and every room in these hospitals. No man will surely say that it is as safe to operate in an infected ward as in a clean one; that it is as safe to operate with dirty hands and instruments as with those which have been thoroughly cleansed.

Dr. Hamilton thought Dr. Thompson had struck the keynote when he said that success depended on cleanliness. The statistics of the old infected hospitals of Europe cannot be justly compared with those obtained in the new hospitals of this country. When Bellevue Hospital became infected, pyæmia and erysipelas was prevented by the thorough use of chlorine. In old hospitals, antiseptic details may be a necessity, not so in new institutions.

Dr. Taylor thought Keith had said he did not disapprove of antiseptic surgery, but that abdominal operations did not afford a proper field for its use.

The discussion closed, and the Society adjourned.

Mrs. Susan Ridgway Barton, the widow of the former distinguished surgeon, Dr. J. Rhea Barton, of Philadelphia, died on March 4th, in the 88th year of her age.

CLINICAL SOCIETY OF MARYLAND

STATED MEETING HELD MARCH 6, 1885.

(*Specially Reported for the Maryland Medical Journal.*)

The Society was called to order by the President, Dr. B. B. Browne, at 8.40 P. M., Dr. Jos. T. Smith, Secretary.

Dr. O. J. Coskery read the first paper of the evening, entitled,

A SHORT NOTE OF TWO CASES OF STRICTURE OF THE RECTUM.

(See Maryland Medical Journal, March 21, 1885.)

At the request of Dr. Coskery, upon motion of Dr. Michael, the discussion of the paper was postponed until the first meeting in April.

Dr. N. G. Keirle followed with a paper entitled

CASE OF RECTO-VESICAL FISTULA IN THE MALE.

He exhibited specimen, and made a few remarks upon the subject of recto-vesical fistula, its causes, syphilis and tuberculosis, and the difficulty of its cure.

The specimen, as entitled upon the Society's notification card, viz.: "Recto-Vesical Fistula in the Male," has not had its claims to attention fully set forth, which nessitates the prolix announcement of the case as "Benign Strictures of the Rectum" at its commencement with recto-vesical and antescrotal urethral fistula. The subject of this concatenate catastrophy, by name Henry Lane, was 35 years old, and in 1859 had, as he thought, dysentery; in 1860 he had urethritis, and produced fæces, pieces of bone and watermelon seed, which he asserted, passed through his urethra, but no urine through anus; digital and speculum examination failed to reach the fistula; therefore, the clinician reached the conclusion that the patient was a malingerer, and ceased to work up the case, so that the fashion of the fæces, whether the old style sheep pellet or the very latest ribbon section, was not observed; the latter, however, upon the authority of Curling, quoted by Van Buren, on the Rectum, p. 279, is "more significant of a contracted irritable external sphincter than of a stricture seated some inches above it." In 1861 he had, frequently, "epididymitis of both sides," but oftener the left, and here also hydrocele; in 1862, from impacted foreign body a fistula formed in the urethra, just forward the scrotum; in 1862, urine passed by way of the rectum; he died in April, 1864; three months before he walked six miles to test his virility, and reported the experiment successful, save that the semen escaped through the urethral fistula. All statements on this topic by the subjects of genital disability are to be discredited, and this filthy detail is only introduced to show the general bodily strength of one so diseased.

Examination, post-mortem, showed a cavity occupying nearly the whole of the upper lobe of right lung, and the usual appearances of chronic phthisis in the lungs throughout; in the larynx there were superficial oval ulcers, and in the colon scattered grey granulations; ½ m. up the rectum, from the anus, a circular fistula about 3 mm. opens directly into the bladder, but in the rectum the orifice is beneath and at the lower border of a band, bridle or bridgelet of rectal tissue about 1 c. m. square and 2 mm. thick, which is still attached at its sides, longitudinally to the gut, but above and below transversely; as also beneath it is free. If it be assumed that this band was originally a pocket, that is, closed along its lower border, it would skid fæces into the bladder and close like a valve against the escape of urine. After the lapse of three years, when the bottom of this pocket has ulcerated out, the obstacle to flow of urine into the rectum no longer exists; about ½ m. of the rectum, in the middle of which is the fistula, is irregularly ulcerated and bare of mucous membrane, except intervening islets, which are yellow and thickened. The walls of the gut over the same extent are thick and pearly white, fibrous, most marked at site of fistula, and tapering to either end, where the sound mucous membrane terminates in a scalloped border; here the calibre of the gut admits the finger, but in the middle of the above indicated space, over the fistula, it is almost impenetrable. The prostate is a mere pus cavity, which explains the epididymitis; the urethra from its meatus to the antescrotal fistula admits about 1 or 2 mm. Is this stricture a result of morbific or violent traumatism? Was the initial lesion a result of impacted foreign body, or of dyssentery or tubercular ulcer? The probabilities favor the last two. The etiology,

like a vicious curve, returns upon itself; ulcers produce strictures and strictures ulcers, but recto-vesical fistula in the male is a rare complication. Van Buren quotes two cases, one from Dr. Valentine Mott, was the result of chicken-bone, the other, a case from Dr. Morrison, London, Eng., in the person of a physician, was a fish-bone; cause of death was septicæmia. Brodie mentions a case in the female due to dysentery, and another in a sea captain who, after a storm in which he was roughly used, began to pass wind by the urethra, and subsequently fæces, as also urine by the rectum. After death coils of small intestines were found adherent to and opening into the fundus of the bladder from localized peritonitis, the result, perhaps, of a blow upon the abdomen. Brodie, from his experience, regards such cases as difficult of cure, and liable to prove fatal. Colston has two cases, one after lithotomy, in which the fistula was cut into the perineum and the bowel pulled down and stitched; cure did not result; the case was under care of Mr. South, of Eng. Another was a case in France of gun-shot wound in the groin, the external opening healed, but patient passed wind by the urethra; twenty years after he began to pass fæces also when bowels were loose, and urine by the rectum when bladder was full; he was alive ten years thereafter, in all a case of thirty years duration. The patient is reported at this date as thin and weak. Colston, from his experience, thinks these cases are difficult of cure, but not necessarily speedily fatal.

I have but one suggestion to offer as bearing upon exact demonstrative diagnosis, a steel sound in the bladder and one in the rectum might be struck together, "easier said than done," as for example in the case before us, in which the overbridging fold presents an obstacle to be overcome, only by indomitable perseverance; the whole, small hand carried up the rectum could go farther than where the gut narrows to the dimensions of a finger; if at this point the hand should extend a finger, perhaps it might feel the hole, or more easily, a sound in the bladder thereto directed. As regards palliative treatment, there is peritoneal section, or preferably, lumbar colotomy; radical cure is an opprobrium chirurgicum.

Dr. B. B. Browne said that recto-vulvar fistulæ were of rare occurrence; that they are seldom mentioned in the text-books, and their existence has been even denied by many gynecologists; he thought that inflammation and suppuration of Bartholin's gland, with subsequent ulceration into the rectum, was the most frequent cause of these fistulæ. He had seen one case upon which he had operated successfully; the history of this case was reported to this Society in November, 1881, and published in the MARYLAND MEDICAL JOURNAL, January 1, 1882, p. 399.

Dr. C. W. Mitchell read a paper upon

THE PROPER RELATIONS OF PATHOLOGY AND CLINICAL MEDICINE.

Dr. J. C. Hemmeter thought that such a subject for discussion was not often presented to a medical society. He would look at the subject from a somewhat different standpoint. This is a time of reform in clinical medicine, and the relation between patholgy and therapy is about to be established. The link is pathological physiology; it is the time for Institutes with experimental laboratories. Pathological physiology deals with diseased processes, an altered circulating fluid, altered respiration, secretion, etc., and can derive its truth only from the clinic, laboratory and experiments.

Dr. A. B. Arnold thought it rather too strong an expression to say that but few practitioners knew anything of pathology. He thought the struggle between pathology and clinical medicine had been fought out long ago, and alluded to the condition at one time prevalent in Germany. It is very well for young men with plenty of time and abundant laboratory advantages to pursue this subject, but the busy practitioner has much else to occupy his time and attention; he is sent for to cure or relieve his patient. The physician is called to see a patient with a tumor, he prescribes, but eventually the patient dies, the pathologist finds upon examination the trouble to have been a malignant disease, and then he says, why what good could treatment have done here; but notwithstanding all the investigations of the pathologist, he is obliged to resort to the same methods of treatment when called upon as the clinician.

FRACTURE OF THE SKULL.

Dr. J. E. Michael related the following: A Danish sailor, about 28 years of age, was

at work on the deck of a vessel, when a man above let something fall upon his head. He received the wound about ten o'clock, and was seen at three o'clock at the hospital. The wound had been tightly sewed by a surgeon before he was sent to hospital. The injury was over the left parietal boss; when seen he had no mental trouble, no fever, and no paralysis. Upon passing the finger into the wound a depression was found. He was put to bed and kept quiet. For two days he did well, then temperature was 101° and then 103°. An incision was made, periosteum removed, and a depression 1 inch in length and ¼ inch deep was found, from the bottom of which a blood clot protruded. A button of bone was removed with trephine, and depressed pieces elevated. A thin clot was found between dura mater and skull; the parts were cleansed by a jet of carbolized water, and covered with iodoform gause; the temperature soon fell after operation, and at this time the patient has no trouble of any kind, and is walking about the wa ds.

Dr. O. J. Coskery related the following, and exhibited specimen of skull. S. H., aged 32, was struck upon left side of head, and three days afterwards was seen by the Doctor. A compound, comminuted fracture of left frontal eminence was found; the patient talked rationally, complained of some headache; his speech, however, soon became thick. The skull was trephined, but erysipelas set in, and patient died. Upon an examination of the parts, it was found that the trephine had been used upon a portion of the skull which had been fractured, and thus broken from its connections, but so firmly was it impacted that it did not yield in the least when the trephine was used upon it.

Dr. R. Winslow thought a depressed portion of bone, irritating the dura mater, should be at once removed, as trouble may at any moment result from it; thought specimens at University of Maryland Museum showed recovery in cases of depressed fragments. Even a slight depression without may have a much larger depressed portion beyond it—that is next the brain.

BONE IN THE RECTUM.

Dr. W. P. Chunn related the following. A patient came to him with trouble in evacuating her fæces, with which she often passed blood; she said she had examined the rectum with her own finger, and thought she detected a needle lodged crosswise in the intestine. The Doctor made first a vaginal examination, and found a body like a needle, and immovable. The curved scissors were introduced, the body cut in half and withdrawn in sections. It was found to be a turkey bone, possibly a rib.

Dr. R. Winslow explained that in cases of depressed bones about the skull, they should either be elevated into position or the trephine used.

BALTIMORE MEDICAL ASSOCIATION.

STATED MEETING HELD FEBRUARY 23RD, 1885.

The meeting was called to order at 8.40 P. M. by the President, DR. J. T. SMITH.

Dr. H. F. Hill reported the following case: Was called in to see a child 18 months old with cold in the nose; gave iodide of Potash in one grain doses; two days after, child died suddenly; gave certificate of heart trouble; does not really know what was the cause of death.

HEALTH AND EDUCATION.

Dr. J. T. King then read a paper on the above subject. He said persons may well know that teachers and pupils are often made severely ill on account of bad air and bad ventilation in our public schools. At a recent meeting of the School Board, Dr. Norris said many of our schools are much overcrowded. I had not the least idea to what extent until I became a member of the Board. It is only a matter of time when disease will break out among the children in the overcrowded schools, and an epidemic will follow. In proportion to the population less money is spent in Baltimore for the public schools than in any other city. Something must be done to give the children more breathing space. In Public School No. 11 the stench was similar to that of a pig-pen. He would not send a child of his to such a school if it never received instruction. The Superintendent of Education, Mr. Wise, said that in one of the schools he visited during the week the infant class contained 107 scholars. In some

of the rooms the children, instead of having nine square feet of floor space and 100 cubic feet of air space, had but three square feet of the former and thirty-five cubic feet of the latter. Men are put in charge of these affairs not because they are highly enlightened on educational topics, but because they are good Republicans or strong Democrats. I will here give the outlines of two extreme cases which have come under my professional notice, whiltt daily called to cases less severe.

Case I.—I learned from an anxious mother that her daughter, from being a bright rosy girl, happy and cheery all day long, had become pale, anæmic, peevish, with loss of appetite and wakeful nights; in short, had developed all the evidences of decline. Her mother said she wanted her to go back to school as soon as possible, as she stood 99 7-10 out of a possible 100. I plainly saw that long hours at school, close application to books and a desire to retain her class-standing were fast undermining her constitution.

Case II.—The principal of one of our schools wrote to the head of a family, which I attended, stating that his daughter had strange nervous attacks at school. I learned on inquiry that this young lady was often compelled to remain up until after midnight, at hard work, in order to keep class-standing. She was fretful, nervous, easily frightened or moved to tears; had terrible headaches and disturbed sleep. What can medicine do in these cases? On women the effects of this forcing system are, if possible, even more injurious than on men. In the pale, angular, flat-chested young ladies we see the effects of this merciless application.

DISCUSSION.

Dr. Waters said he was deeply interested in Dr. King's paper; it was full of important points. Some years ago, when he was connected with the schools, many of them were so overcrowded as to make the odor worse than the dissecting room; it is marvellous that disease does not occur more frequently among the children. We are not likely to have any marked improvement in school buildings until the growth of the city makes larger buildings necessary.

Dr. Gibbons said he had visited a number of the public schools and had never seen any as bad as described by debaters. Some years ago there had been improvements in ventilation, but much more was needed, but it is easier to criticise than to improve. Our public schools are as well lighted and ventilated as our private schools.

Dr. H. F. Hill said he did not hear of the evil effects of ventilation in our factories. He asked if Dr. King thought the hours of study too long.

Dr. Rohe said he visited two schools, one of which was well-ventilated but badly lighted; the other was overcrowded. In the school-room,12 feet high and 18x18 feet, there were 65 children; it was badly lighted and ventilated. The increase in nearsightedness is caused by bad lighting of the schools.

Dr. Earle said, in answer to Dr. Hill, there is no difference in hours of study required in grammar and primary schools.

Dr. Ingle spoke of the evil of compelling the children to go into the yard during recess regardless of the weather.

Dr. Hill wishes to call attention to the practice teachers have of sending pupils to the homes of absent ones; they are often in this way brought in contact with contagious disease, and possibly convey it back to the other pupils in school.

Dr. Waters thinks the School Board passed a rule some time ago prohibiting this practice.

Dr. King, in closing this subject, spoke of two cases that came under his knowledge; one had headache and the other was made sick by examinations.

On motion, the Association then adjourned.

G. H. Chabot, M. D.,
Secretary.

A young Philadelphia surgeon has lately received high honors in Belgium. His name is Francis W. Strain, a graduate of Jefferson Medical College and surgeon of one of the steamers of the Red Star Line, "The Nordland." He lately removed a tumor from the face of a lady who is one of the near relatives of the King of Belgium. In recognition of his skill, the young surgeon has been elected a member of the Royal Society of Surgeons and has been presented with a royal gold medal, which has attached to it a fac-simile of King Leopold's crown.—*Phila. Med. Times.*

Correspondence.

INVALID FEMALES.

LURAY, VA., March 21, 1885.

Editors Maryland Medical Journal:

Woman is instinctively modest, and her refined nature entitles her to the most respectful, courteous and delicate regard at the hands of the medical profession, in her relations as patient. As the graces, beauty and attractions of her perfect womanhood command our admiration and homage, so, should she in affliction and suffering, command our tenderest care and sympathy. Never should there be even a seeming failure upon the part of the physician to recognize and appreciate the obligations of the purest refinement when called upon for advice, counsel and treatment in regard to the many diseases peculiar to her sex. Disease and suffering may, and often do, rob her of health and bouyancy of spirits, but can never take from her the characteristic delicacy and refinement of her nature. These are her's—sacredly her's—and she should guard them with a jealous care How studiously then we should avoid the slightest approach to bruskness of manner and deportment in the presence and treatment of our female patients. Until we recognize their claims upon our courtesy, kindness and gentleness, they will not willingly and confidingly commit their health to our keeping. That suffering female invalids residing in the country, often fail to visit our cities (more than once) and avail themselves of the conceded skill of their physicians, is because of the indelicate and rude manner of the examinations to which they are subjected, I am an unwilling witness. And it is the knowledge of this fact, Mr. Editor, which induces me to call your attention to it, and ask that you urge, through your valuable Journal, the importance of refinement and reformation in professional manners towards our rural female patients when visiting the cities in pursuit of health. I know one invalid lady—truly a lady by instinct, association and education—who declares that she will suffer on and die, rather that submit to the ordeal of a second "brutal" examination such as she was subjected to. Her indignation may be imagined from her own remark, "I was treated like a pig." Physicians of renown and in high places are usually the offenders, and must plead guilty to this harsh impeachment. They seem to assume that their reputation excuses any departure (upon their part) from professional propriety and delicacy, and that female modesty should be held in abeyance in the presence of their exalted dignity. The conventional rules of polite society accord to ladies under all circumstances respectful recognition, and they have a right to demand of medical men the sacred observance of every courtesy due them as patients, rendered almost fastidious sometimes by disease and much suffering. These suggestions are the result of what I know to be the feelings of many invalids, who would gladly seek medical aid in the cities (the seats of advanced learning), but for the impression prevailing among them that female patients do not receive that polite and delicate attention which their sex should command. This letter is written in the interest of the sick, and will, I hope, be so regarded.

In my reference to physicians of renown, I disclaim any intentional disrespect; for I am sure when I send them a patient they will not treat her "like a pig."

Respectfully,

GEO. W. RUST, M.D.

OPERATIVE DILATATION OF THE ORIFICES OF THE STOMACH.—*Prof. Loretto*, of the University of Bologna, has called attention to the advantages of this method of treating strictures seated at either orifice of the stomach. It is adapted only to cases of a chronic and non-malignant character—simple or fibrous stricture, and in the case of the œsophagus, also cicatricial contraction after injury. It consists of digital dilatation of the pylorus or instrumental dilatation of the œsophagus; the former being intended as a substitute for resection of the pylorus, the latter as a substitute for gastrostomy. He gives the history of a few cases in which he had executed one or two of these operations with perfect success. Two of the patients were exhibited before the Medical Society of Bologna. Two other cases have been also operated on successfully by two other Italian surgeons, and it is reported that Billroth has also dilated the pylorus.—*T. Holmes, F.R.C.S., Brit. Med. Jour.*, Feb. 21.

Editorial.

THE INDEX MEDICUS.—The announcement of the suspension of the publication of the *Index Medicus*, made at the close of last year, occasioned no little regret and disappointment to the warm friends and supporters of this valuable journal.

The utter failure of its publisher, Mr. Leypoldt, to make it a financial success, after several years of earnest effort and serious pecuniary loss, was accepted as its final discontinuance. We are now pleased to announce that arrangements have been made with that enterprising and well-known publisher, Mr. Geo. S. Davis, of Detroit, to continue the publication of this journal, on the same general plan, and with the same regard to typographical accuracy and finish as heretofore. On account of the delay required to perfect this arrangement with Mr. Davis, the first number of the *Index* for the current year will comprise the literature of January, February and March, after which time it will appear monthly. When it is borne in mind that Mr. Davis has determined to carry on this enterprise in spite of the fact that thus far it has not been pecuniarily remunerative, we feel assured the friends and patrons of the *Index*, and the profession at large, will give a more liberal and generous support to his disinterested efforts in behalf of higher medical literature.

The present publisher should not be allowed to carry on this work without a cordial support and liberal aid upon the part of the profession, in whose behalf the enterprise has been undertaken.

In a circular received from the editors, Drs. J. S. Billings and Robert Fletcher, the request is made that all exchanges, and books and pamphlets for notice be sent to *The Index Medicus*, Washington, D. C.

SELF-MUTILATION IN ANIMALS.—Numerous instances are on record in medical literature in which men and women have performed mutilating operations upon themselves. These cases have frequently, if not usually, occurred in persons laboring under some strong mental excitement or delusion, and the organs of generation are commonly selected for the sacrifice.

What proportion of these individuals are actually insane it is not easy to say, but certain forms of insanity, especially religious monomania, undoubtedly predispose to self-mutilating operations. The religious ascetic of the middle ages who practised self-torture for purposes of discipline and as an expiation of often imaginary offenses, the young Roman who thrust his arm into the flames to show his enemies how his countrymen despised pain, and the melancholiac of to-day who castrates himself in expiation for some past impurity or to place himself beyond the reach of future temptations, are probably nearer related in their essential elements than might appear from a consideration of their various motives alone.

It was not so generally known, however, that animals are subject to similar practices. Yet such appears to be the case from an article in the last number of the *Dublin Journal of Medical Science*, by "P. S. Abraham, M. A., B. Sc., F. R. C. S., Curator and Member of the Court of Examiners, R. C. S. I.; and Member of the Council of the Royal Zoological Society of Ireland." This writer has collected from the different zoological stations a number of instances in which animals have eaten off portions or all of their tails, a limb, or of the flesh of the body. Among instances given is one of a lioness in the gardens at Dublin who, one night, devoured six inches of her tail—hair, skin, bones, everything. After an intermission of nine days, marked by great restlessness, she again went to work, demolishing during the night the greater part of the remainder of the organ. After another intermission the destruction proceeded so that in four weeks from the beginning there was nothing left but a "butt" of some 4 inches. She was unable to reach this, but this did not deter her, however, for after some weeks she began to gnaw off the skin and subjacent tissue of the dorsum of the right hind paw, the whole extensor surface being laid bare. Meanwhile the animal suffered extreme pain; the stump of the tail was in a constant quiver, and the animal limped about the cage on three legs. There was nothing in her condition to account for this strange conduct. Remedies had no effect, and it was deemed advisable to destroy her on account of her suffering and extensive wound surface. Post-mortem revealed no lesion. Her previous health had been good, but her offspring were unhealthy, mostly becoming rickety and dying young. For a year prior to the above occurrences she had not been "in season."

Being lead by the above case to investigate the subject further. Mr. A. made inquiries of the authorities of a number of other gardens with the result of showing him that such events were not unknown among animals kept in confinement. A gradual gnawing and picking away of the tail is not uncommon in monkeys and occasionally occurs in dogs, rats and other animals. Among the animals cited as having consumed their tails or legs are a hyena, a wolf, a jaguar, a chulah, a parrot, a leopard and a tigress. Monkeys are especially liable to the practice. Nearly all the instances occurred in females. Various causes are assigned by the writers as accounting for the practice, a wound of the tail, a faulty state of the blood, a disease or irritation of the skin, scrofulous sore, madness, etc. In some cases there was no apparent cause. Dr. Abraham is inclined to regard the abnormality as due rather to something akin to mental derangement; there was always some interruption or disturbance in the sexual functions and the condition was probably but "one of the manifestations in the lower animals of that protean affection which we call hysteria." Great excitement accompanied the act in some instances.

Bay-View Asylum Management.—A letter appeared in the last Baltimore Sunday *American*, which had been addressed to the Mayor by Mr. Jos. Merrifield, the V. P. of the Society for the Protection of Children from Cruelty and Immorality, charging that the resident physicians at the Bay-View Asylum were young and inexperienced, and that the insane were left without any medical attention or treatment. Nothing could be further from the truth, and Mr. Merrifield was compelled two days later to acknowledge his error, and to state that Drs. Jones and McIntosh, the resident physicians, were neither of them "young" nor "inexperienced," and that a thoroughly competent physician, Dr. Noyes, was already in charge of the insane patients. This retraction is nothing more than right, as Bay-View has probably never had such excellent medical service as at this time, and we hope that the two schools—the University of Maryland and the College of Physicians and Surgeons—who have its medical affairs in charge, will omit nothing necessary to a most complete and scientific treatment of the sick poor of the city cared for there.

Rudeness to Female Patients.—Our correspondent, a much esteemed and highly cultivated physician, residing in our sister State, has requested, in another column, that we should urge in this Journal the importance of refinement in professional manners towards rural female patients when visiting the cities in pursuit of health. In inviting attention to this subject we request our readers to read our correspondent's manly and highly proper treatment of the points at issue. We have not a word to say in justification of rudeness to the noble sex which embraces our mothers, sisters, wives and daughters. Not one of our readers will admit that any female patient should be treated with other than the most marked courtesy, consideration and kindness. Moreover, every one of our readers would hiss and insult the physician who would degrade his calling and his manhood by maltreating an unfortunate female patient. We also believe that no class of men has a higher and truer appreciation of woman than physicians, and discourteous treatment to female patients is not consonant with the chivalrous pratices of our profession. How is it then that a member of our profession finds it necessary to remind our readers of a lack of courtesy upon the part of certain city physicians to rural female patients? Physicians, as a class of men, fall into the habit of plain speech and open statement. They often become frank and blunt to a painful degree, and adopt methods of expression which, to say the least, are at times indelicate and distasteful to very sensitive and refined people. The habit of being brusque and pointed in conversation with patients grows upon some physicians to an extent that it even borders on rudeness and indecency. This is especially true in respect to their relations with poor patients and timid females. The very physicians who are most guilty of this conduct are hardly aware of it, and at heart do not feel the roughness they unconsciously give expression to. These men are oftentimes really kind, generous and sympathetic, and would resent in others the very conduct they are chargeable with. Again, not a few physicians cultivate familiarity with their patients which is at times as undignified as it is disrespectful. Their excessive familiarity is sure to breed contempt, and often resentment. Patients do not always receive kindly the patronizing manner and lordly bearing of

their medical advisers. Female patients certainly claim kindness, consideration and most marked courtesy from a physician. It should make no difference how humble, nervous, whimsical or irascible a female patient may be; the physician should not lose sight of the fact that she is under all these conditions entitled to gentle and courteous treatment. These are the very patient who will most vex his temper and then resent his conduct towards them if it displays any of their weakness. Under the most favorable circumstances the physical examination of a female is a trying and painful ordeal. To the physician it is a professional duty which should never be performed without a full appreciation of its importance and significance. To the patient it is a sacrifice of sentiment and of feeling of a most embarrassing aud painful character. Considering then the embarrassing relations which the female patient sustains to her physician when she submits to the ordeal of the treatment rendered necessary by the nature of her ailments, can any excuse be made for roughness, rudeness or violation of the proprieties of a professional examination? We think not. We would therefore emphasize the importance of our correspondent's suggestions, and urge their consideration by those gentlemen who deal with the infirmities of the gentler sex.

Miscellany.

The Treatment of Pulmonary Consumption.—In an admirable series of clinical lectures on the Treatment of Disease, delivered in King's College Hospital during the past year by Dr. J. Burney Yeo, the treatment of pulmonary consumption is summarized and discussed from the standpoint of the following indications:

(1) In the first place, to prevent or amend those faults of constitution, organisation and development which predispose to the acquirement of this disease.

(2) To prevent or cure those local pulmonary affections which may induce a tendency to this disease, even where no constitutional predisposition is found to exist.

(3) To prevent the possible spread of the disease by conveyance of its germs from the sick to those who are necessarily brought into close contact with them.

(4) To endeavor, so far as possible, to antagonize the influence of the infective organism *in situ*, and in its action on the constitution. To attempt to hinder the progress of its development and reproduction, and its extension to the sound parts of the affected lung, and also to the sound unaffected lung, and to prevent the infection of other organs. This is what is understood by antiseptic treatment.

(5) To lessen and remove the *fever* and other constitutional disturbances dependent on the the infection of the constitution, as well as on the local inflammation.

(6) To lessen and arrest the local irritation and inflammatory and catarrhal changes when evidences of such make their appearance.

(7) To improve the disturbed and defective nutrition by all the means in power, medicinal, regimenal, climatic, &c.

(8) To relieve the various distressing symptoms that occur during the course of the malady.

(9) To diminish as far as possible the evil consequences of the several grave complications incident to its course.

Iodoform Eruption.—Dr. Neisser (*Deutsche Med. Woch.*,) July 1884) has observed seven or eight instances in which the external employment of iodoform has occasioned an erythematous affection, characterized by the formation of small vesicles and closely resembling acute eczema. In a few hours after the application a deep redness of the surfaces comes on, accompanied by violent burning and itching, then vesicles filled with clear fluid appeared, and soon formed crusts. This resulted, in some cases, from a single application. He defines the disease as an acute dermatitis, and likens it to mercurial eczema. Many patients are peculiarly susceptible, and the slightest trace of iodoform in any application will cause this eruption to appear. (*Journal of Cut. & Ven. Dis.*, Feb. 1885.) I have seen this eruption several times following the application of iodoform to wounds, and at first it looks very like as if the wound was taking on an erysipelatous action. I well remember the consternation the appearance of this eruption caused me in the first case of amputation (of the leg) I dressed with iodoform. I felt sure, especially as the temperature was somewhat elevated, that ery-

sipelas had set in. This was within 48 hours of the application from the time of the operation. The patient, however, kept getting better instead of worse, and soon the case was recognized as one of iodoform rash.—*Dr. Shepherd, in the Canada Med. and Surg. Jour.*

A Layman's View of Cocaine.—Within the last few months a boon has been conferred on humanity so great that all the cost of all the laboratories of all the lands in Christendom could have been a small price to pay for so precious a pearl. It came into the world never again to leave it, unheraled, unexpected, from the laboratory of science, to deaden for a few minutes and then restore to life the organs of sight, so that operations on the eye, hitherto dreaded, may be performed without the slightest pain. The chemists may modestly say that this discovery was an accident not to be compared in significance with Avogadro's law. That may be so, yet this sort of accident does not happen in Africa or the Fiji Islands—it "happens" where there are universities and laboratories and trained men, able and ready to observe, discover and apply.—*President Gilman, in Johns Hopkins University Circular.*

Diphtheria.—Chinoline, one of the most actively antiseptic agents at our command, has been utilized as a local application to diphtheritic membrane. It may be used in combination with glycerin. Donath reports very favorable effects from its use upon the local manifestations of the disease.—*Phila. Med. Times.*

Case of Cæsarian Section Performed by the Patient Herself.—The following remarkable case was related by *Dr. Van Guggenberg*, and the patient exhibited at the last annual meeting of Bohemian physicians at Tetschen. On September 28, 1876, he was summoned at two in the morning to see a woman who was said to have cut open her abdomen. He found the patient lying in a miserable house in a wretched and dirty bed, exhausted and bloodless, and only capable of making affirmative and negative signs. On removing a dirty petticoat which covered her, an incised wound was seen on the right side of the abdomen, passing downwards and inwards, from which a somewhat large coil of intestine protruded, the greater part of which, covered with dry blood, rested upon a dirty blood-soaked straw-sack. Hemorrhage seemed to have ceased from every part of the wound, and the uterus was contracted to the size of a child's head. A fully-developed, but dead, male child lay between the patient's knees. Clean linen was procured from a neighboring house, and with a piece soaked in oil, the protruding intestines were carefully wiped and returned, and the wound sewed up, the peritoneum being included with the skin. The incision was about 3½ inches long, and slightly S shaped. It was dressed with a five per cent. carbolic solution, fixed with strapping, and the abdomen carefully bandaged. By the afternoon the patient was able to speak, and next day the history was taken. She had had some children previously, four of whom had been born without medical assistance, two with forceps, and one after craniotomy. The pains began between September 24th and 25th, ceased in the afternoon and came on again on September 26th, when the midwife stated that she felt the presenting head on vaginal examination. On September 27th convulsions came on, according to the patient's account, accompanied by agonizing pain and great distension of the abdomen; the movements of the child ceasing, the pain and distension became so severe that the patient determined to perform Cæsarian section of which she had heard. She therefore took a razor, and divided the skin slowly; she then made a second and a third incision, and finding the child not yet appearing, made another cut, which caused a large jet of blood to escape, and exposed the placenta, which she removed. One foot of the child came into view, which she seized and pulled upon until the whole of the body came through the wound, the head requiring the execution of all her force; she divided the umbilical cord, laid the child (which she believed to be dead) beside her on the bed, and threw the placenta on the floor. She had passed neither urine nor fæces since September 24th. The progress of the case was very good; urine was passed on the afternoon of September 28th, but the first stool not till October 2d. The pulse reached 120° on the day after the operation, but was never

again so frequent; the temperature is stated to have been not very high; and although there was a considerable amount of exudation from the wound, it had united by October 3d. The patient soon returned to work, and has been ever since in perfect health.—*Brit. Med. Jour.*, Feb. 21.

The Fourth Annual Commencement of the Baltimore Medical College was held at the College Hall, on Linden Ave., in this city, on March 12th. The degree of M. D. was conferred upon eight graduates. The Faculty prize, which consisted of a gold medal, was conferred upon E. M. Littlejohn, of Virginia, for the best general examination. The prize for the best Original Thesis was awarded to John Tomlinson, of Pennsylvania.

The valedictory address was delivered by Prof. Wm. Lee, Dean, on the subject "Responsibility of the Medical Man." After expiating upon the high calling and responsibility of the practitioner of medicine, the speaker urged upon the graduates the importance of continued and earnest study during their professional lives if they would attain a confidence in themselves and inspire confidence in others.

In closing, he advised in all their transactions as practitioners of medicine an adherence to the Code of Ethics of the American Medical Association. At night a banquet was given to the graduating class, at Barnum's Hotel, by the Faculty.

The After-Treatment of Vaccine Vesicles.—Dr. F. P. Atkinson suggests the following directions to be given after vaccination: 1. If the arm become red and inflamed, apply powdered oxide of zinc, starch, or flour. 2. Never apply moisture of any kind, whether in the shape of a poultice or cold compress, as it tends to convert the vesicles into open sores. 3. Never apply oil to prevent the clothes from sticking to the arm, as it will do nothing of the kind. If the scabs be rubbed off and the marks be deep and not inclined to heal, it is best to apply some pieces of lint (of just the size of the sore) soaked in dilute nitric acid lotion (seven minims to the ounce), and keep them covered with oiled silk.—*British Medical Journal.*

The True Way to Estimate Success in Educational Institutions.—Let me protest against the common method of estimating intellectual work by numerical standards alone. I have heard it said that some men are possessed by a statistical devil. They can only think in figures; they will ask, in respect to a new acquaintance, how much is he worth; of a library, how many volumes; of an orchestra, how many pieces; of a college, how many students. I have known the expenses of an institution made a dividend, and the number of scholars the divisor, the quotient representing the cost of each pupil. All this is wrong, absolutely and wholly wrong. If such a standard were allowable, the largest number of scholars taught by the cheapest teachers would be the greatest success. *It is not the number, but the quality of students which determines the character of a high school.* It is important to count; it is better to weigh.—*President Gilman, in Johns Hopkins University Circular.*

Quinine as a Parturient.—Dr. Andrew Mullen ("British Medical Journal") professes to have produced contractions of the uterus by means of quinine under circumstances in which ergot had failed. After citing several illustrative cases, he draws the following inferences: 1. Quinine (or quinetum, which he also recommends), when administered in doses of four grains, will occasion uterine contractions in the course of half an hour. 2. Cinchonism and other unpleasant after-effects are not produced. 3. The pains are intermittent in character, and thus resemble the normal uterine contractions. The condition of tetanic contraction does not occur. 4. Post-partum hemorrhages are not likely to result after the use of quinine, because the uterus is not left in a state of exhaustion after delivery.—*N. Y. Med. Jour.*

Medical Items.

Prof. Hyrtl will complete his half century in medicine during this month, and we learn that the Senate of the University and other learned bodies in Vienna are making arrangements to celebrate the event, and present their congratulations to the venerable anatomist.—*Med. News.*

The patient upon whom Prof. L. McLane Tiffany performed nephro-lithotomy has left the hospital well.

Acne is often reflex from urethral irritation. Dr. S. Sherwell obtained marvellous improvement in the faces of two patients, after long treatment had failed, by passing cold sounds every third day. The urethra was found sensitive, especially at about the junction of the membranous portion with the prostatic.—*Journ. C. and V. Dis.*

Dr. A. to Dr. B., discussing magazine literature: "Now I take *Life* every week." Dr. B., grimly: "I suspected as much."—*Med. and Surg. Rep.*

Dr. Osler, of Philadelphia, has recently delivered the Gulstonian Lectures, three in number, at the Royal College of Physicians, in London, on "Ulcerative Endocarditis."

Dr. Detmold, of New York, regards as a pathognomonic sign of syphilis, a permanent œdema over the anterior surface of the tibia, in cases of periostitis of that bone. In no other case, in all his experience, has he ever seen it entirely disappear, and hence its great diagnostic value.—*Med. and Surg. Rep.*

Martineau, says the *Lancet*, has succeeded in rapidly curing suppurating buboes by touching them with Paquelin's cautery.—*New York Med. Journ.*

Dr. Buchanan was again found guilty by a jury, at Philadelphia last week, of issuing bogus medical diplomas. A woman named Russell, who was tried at the same time with him, was acquitted on the criminal charge. She testified that, although she displayed a sign as a doctor, she had graduated from no medical school, and that the M. D. following her name meant "Money Down."—*Boston Med. and Surg. Journ., March 19th.*

The thirty-third annual commencement of the Woman's Medical College of Philadelphia was held at the Academy of Music on the 11th instant, graduating a class of twenty-two. W. W. Keen, M. D., delivered the address to the graduating class.

By a new treaty between Great Britain and China, the control heretofore exercised by the former government over the internal tariff of the Chinese Empire, with reference to the importation of opium, is abrogated, and China is to have complete freedom of taxation of the drug.—*Boston Med. and Surg. Journ.*

The relative numbers engaged in some of the professional callings in the United States, as shown by the census returns of 1870 and 1880, were as follows:

The number of clergymen in 1880 was 64,698 against 43,894 in 1870; the number of lawyers was about the same—in 1880, 64,147; 1870, 40,736; the number of physicians in 1880 was 86,000; in 1870, 62,000; the number of teachers and scientific men in 1880 was 228,000; in 1860, 110,000; the number of dentists in 1880 was 12,314; in 1860, 7,839. These figures are to be interpreted in the light of an increase in the total population during the decade of thirty per cent.—*Boston Med. and Surg. Journ.*

Mrs. Marshall Hall, the widow of the great physiologist, died recently in Nottingham, England, at the age of 83.

Prof. Frederick Theodore v. Frerichs, the distinguished author of the well-known work on the Diseases of the Liver, died recently in Berlin, Germany. He was born at Aurich, in Hanover, March 14th, 1819.

The Tenth Annual Session of the State Medical Society of Arkansas will be held at Little Rock, on April 22, 23 and 24.

The Missouri State Medical Society will meet at St. Joseph, on May 12th.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U. S. MARINE HOSPITAL SERVICE FOR THE WEEKS ENDING MARCH 14 TO 21, 1885.

Bailhache, P. H., Surgeon, detached as President Board of Examiners, March 10, 1885.

Purviance, George, Surgeon, detached as member Board of Examiners, March 10, 1885.

Austin, H. W., Surgeon, detached as recorder, Board of Examiners, March 10, 1885.

Sawtelle, H. W., Surgeon, detailed as Chairman of Board for physical examination of officer of the Revenue Marine Service, March 17th, 1885.

Armstrong, S. T., Passed Assistant Surgeon, granted leave of absence for thirty days, March 16th, 1885.

Ames, R. P. M., Passed Assistant Surgeon, detailed as recorder of Board for physical examination of officer of the Revenue Marine Service, March 17, 1885.

Original Article.

ACUTE UNCOMPLICATED LOBAR PNEUMONIA; ITS ETIOLOGY, PATHOLOGY AND TREATMENT.*

BY J. I. PENNINGTON, M. D., OF BALTIMORE.

I have selected this subject not that I have anything new or original to offer, but rather for the opportunity it affords of bringing before this Society, for discussion, the teachings of some of the more prominent authorities, as to the nature or essential character of the disease. The fact that the disease, in different individuals, manifests great diversity in the degree of its symptoms, in its course, duration, and its mode of resolution; and that persons of all ages are liable to an attack, which frequently proves fatal, thereby removing from among us many valuable lives; together with the obscurity as to its cause and pathology, and the uncertainty as to a rational plan of treatment, renders the subject a most interesting study.

The earlier writers do not seem to have had a clear understanding as to the nature of the disease.

It was by them characterized as peripneumonia. More recently the term pleuropneumonia was used, and it was defined as a true inflammation, originating in the pulmonary vessels, which were particularly disposed to inflammation.

The only recognized distinction between pleurisy and pneumonia was in the character of the pain, which in the former was more violent. It remained for Lænnec, who laid the foundation for physical diagnosis, to describe accurately the difference existing between the two diseases. Since his time important advances have been made, but we have not yet arrived at a time when authorities agree as to the true character of the disease.

Dr. Bigelow, of Washington, in answer to the question, what is pneumonia, says it may be defined as an inflammation of the vesicular structure of the lungs, resulting in a clogging of the interior of the alveoli with products of such inflammation, which render them impervious to air. Its chief clinical feature is pyrexia. This definition is perhaps in accordance with the views of the majority of practitioners of the present day; and it is from this standpoint that we inaugurate a plan of treatment. It is, however, not accepted by all.

Dr. Flint, in his last work, characterizes it as a febrile disease, the pulmonary affection being the local manifestion. In explaining his theory I beg leave to use his own language:

He says: "From the relatively excessive amount of exudation, its deviation from the branches of the pulmonary artery, its complete removal by absorption and expectoration, an extension of the local affection to a second or third lobe, and the laws of the disease as regards the greater liability of the lower lobes, and of the lower lobe of the right lung, these are points which, to say the least, are suggestive of a dependance upon a constitutional morbid condition, the latter being essentially the disease."

He further says: "It is not easy to reconcile the pathological facts just stated with the doctrine that the pneumonic products are the result solely of a local inflammatory condition; and if a prior constitutional condition be essential, that condition is a fever." In support of the above argument, he further says, "the local affection is never produced by local causes; and all the knowledge which we at present have of the causation is in favor of the primary action of the cause being constitutional."

Juergenson (Zeimmsen) says croupous pneumonia is a constitutional disease, and is not dependent upon a local cause. That it is a specific infectious disease with a local lesion, due to a specific blood poison. Wilson Fox, Loomis and Draper say it may be due to many poisons. Draper says it is a conservative process by which a *materies morbi* is eliminated from the system.

A committee was appointed in England, during the year 1883, to examine this subject. In their report, based upon a study of 350 cases, they say, "We think the evidence before us is insufficient to support the doctrine that pneumonia is a specific fever, whose chief local manifestation is in the lung. Like other respiratory diseases we find it prevailing in certain states of the weather, and apart from all else, the great regulator of its frequency is season. It appears to have no direct association with any specific or conveyable disease."

That pneumonia is sometimes due to poisonous gases, I do not think can be doubted, but whether directly as the ex-

*Read before the Baltimore Medical Association.

citing cause, by causing a fever with a local lesion, or more remotely by lowering the general health, and placing the system in such a condition that on slight exposure an attack is brought about, I am unable to say, but I am inclined to accept the latter as the explanation. It would seem that a pneumonia caused by the passing of poisonous blood through the lungs must necessarily involve all of both lungs, which, as a rule, is not the case, the disease being generally confined to a portion of one lung. And, furthermore, if, as according to Dr. Draper, the process be conservative or eliminative, the very object for which the process is instituted by the system, is defeated, that portion of lung tissue involved being cut off from the general circulation at the time, is totally incapacitated for any function whatever; nor is it accomplished by the exudation, for the greater portion of the exudate is taken up by the absorbents, and again passed into the system.

Dr. Wm. D. Schuyler advances a theory explaining the phenomena presented by the disease, which I am very much inclined to favor. It is that pneumonia is not an inflammatory disease, the local affection—the pathological process in the lungs—is not due to inflammatory action, nor is it essentially a fever of an infectious or specific character, but rather a functional disturbance of the normal tonicity existing between the heart and the pulmonary capillaries, and that the immediate cause is a functional insufficiency of a few or many of the pulmonary capillaries.

The causes are predisposing and exciting. The predisposing causes are any acute or chronic influences which conduce to or permit the development of a non-resistant, atonic condition of the capillaries of the lungs, such as age, exhausting conditions, mal-nutrition, nervous exhaustion from any cause, from labor, especially mental labor with anxiety and loss of sleep, alcoholism, occupations confined to heated atmosphere, which promote debility of the skin and render it sensitive to atmospheric changes, all of which predispose the system to an attack. The exciting cause may be any influence which suddenly determines the venous blood inward upon the already debilitated pulmonary circulation with such volume and pressure that the force transmitted shall overcome the existing tonic capacity of the pulmonary capillary vessels, and render them for the moment insufficient for their functions. A sudden chilling of a portion of the body, or any cause which may disturb the normal equilibrium of the circulation.

According to his theory a sudden chilling of any portion of the body results in an internal determination of the venous blood upon the pulmonary circulation; the capillaries having lost tone from some predisposing cause, under the exaggerated pressure dilate, then follow at first a slowing and finally an arrest of the blood current. In consequence of this obstruction a local aggregation of blood occurs upon the proximate side of the obstruction, which quickly results, on account of the rapidly incoming blood, in a decidedly hyperæmic condition. On the contrary and for the same reason upon the distal side of the obstruction there results a corresponding anæmia. In the beginning of the process it is slight, but the occlusion of the capillaries involved causes the blood to seek other channels, which, also being in a weakened condition and under pressure, likewise become involved. In this manner a lobe or even the entire lung may become consolidated.

The constitutional symptoms, namely, elevated temperature, frequency of the pulse, disturbance of the respiratory functions, mental disturbance, loss of appetite, failure of the excretory function, are accounted for by the obstructive filling of the afferent veins with carbonized blood, which setting back upon the brain with pressure exhibit nervous action. At the same time there exists arterial anæmia, hence nutrition suffers from a limited supply of properly oxidized blood.

Shortly after the stage of engorgement the elements of the blood, under pressure from the action of the heart, pass through the capillary walls into the extra-vascular spaces, which, being small, soon become filled to their utmost capacity. The exudate, according to Dr. Flint, amounting to from 2 to 4 pounds or ½ to ¼ of the entire blood, the lung being distended equal to a full inspiration.

The elements of the blood having now passed out of the capillaries, they become empty. And under the lateral pressure of the exudate collapse throughout the area involved.

During the pathological process, in cases that terminate favorably, the lung is sup-

plied through the bronchial arteries with sufficient blood to sustain life, stimulate the lymphatics and promote softening of the exudate. In a short time, from softening of the exudate, and its removal by lymphatics, and by expectoration, sufficient shrinkage occurs to relieve the lateral pressure upon the capillaries, when the circulation is again resumed and the exudate with varying rapidity is removed, leaving the lung structure uninjured. This explanation of the phenomena presented by pneumonia is partially sustained by well-known laws in physiology. Foster says, in order that the blood may be a satisfactory medium of communication between all the tissue of the body, two things are necessary. In the first place, there must be through all parts of the body a flow of blood, or a certain rapidity and general constancy. In the second place, the flow must be susceptible of both general and local modifications. The first of these conditions is dependent on the mechanical and physical properties of the vascular mechanism. The second of these conditions depends on the intervention of the nervous system. Hence any interruption of the normal flow of the blood, whether it be from capillary insufficiency, from a weakened condition of the capillaries or a disturbance of the nervous influence regulating the flow of blood through the pulmonary capillaries, must result in the condition described.

This theory is further sustained by Dr. Stokes, who describes a stage of arterial injection antecedent to that of engorgement; and by Dr. W. Fox, who characterizes the stage of engorgement as an intense congestion of the pulmonary vessels, and by commencing œdema of the lung. Microscopic examination of the capillaries of the pulmonary artery, show them to be loaded with blood.—*See Rindfleisch's Pathology.*

Rindfleisch, *Pathological Histology*, p. 425, 1872, says: "A recently hepatized piece of lung is injected from the pulmonary artery with a blue gelatinous mass, then hardened and thin sections made. Upon these sections we find the alveolar walls exactly constituted as though we had injected a perfectly healthy lung, (*a*) the same number of intervascular and vascular nuclei, that most external layer of scattered, rudimentary nuclei which we regard as the remains of the epithelium, all unchanged. And yet within the lumen (of the alveoli) there is a finely filamented coagulum, (*b*) which encloses numerous colored and colorless cells." The cells, he says, must, therefore, proceed directly from the vessels, they must have passed through, migrated through their walls, although we cannot discover the slightest abnormal opening upon the walls.

If the pneumonic process be inflammatory it certainly does not pass through the same stages of inflammation affecting other organs, which generally results in the distruction by suppuration of the part involved.

In pneumonia the softening and suppuration seems to be confined to the exudate, and when its cause and source is determined the character of the disease is evident.

TREATMENT.

In the treatment of pneumonia a great variety of remedies have been used; among the more prominent may be named blood-letting, general and local, calomel, tartar emetic, aconite, verat. viride, quinine, carbonate of ammonia, alcohol, blisters, hot external applications, ice-bag, ice-packing, hot drinks and cold drinks, all of which may, under certain circumstances, be useful, with one exception. According to my judgment I do not believe the external application of ice could possibly have a beneficial effect.

With blood-letting, calomel and tartar emetic my experience has been limited. I have used aconite, but have found it inferior to another remedy, of which I shall speak later on.

It is claimed by some if quinine be given early, in large doses, it will abort the disease. The indications for treatment vary with each stage of the disease.

In the first stage, that of arterial injection, and following engorgement, we should so direct our treatment as to limit as much as possible the pathological tendency. The second stage, that of exudation, requires much the same treatment. The third stage or stages of resolution requires an entire change in our remedial measures. In the first stage of the disease, whether the patient be sthenic or asthenic, young or aged, I believe the indications for treatment are the same, which is to lessen the amount of engorgement and exudation. It is in this that the danger lies. According to Dr.

Flint, as I have said, the exudate may amount to from 2 to 4 pounds or ⅛ to ¼ of the entire blood, which is drawn directly from the circulation; in addition we have involved one of the most important organs of the body. Bleeding in certain cases is perhaps the most prompt remedy we possess, as it at once diminishes the flow of venous blood into the right side of the heart, also in the pulmonary artery, relieving for a time the undue pressure upon the capillary vessels; and if *supplemented* by such remedies as lessen the frequency and force of the heart's action and relax the skin, the desired result may be accomplished. The remedy I have learned to rely upon with most confidence is Norwood's Tinct. Verat. Viride, which, if given early, and with care, I believe will do more to arrest the progress of the disease than any remedy we possess. It has this advantage over bleeding: while it lessens the amount of engorgement and exudation, it does not deplete the system.

My mode of giving it is this. I order for an adult tr. verat viride, ℥i; tinct. opii deod., ℥i; tr. card. lev., ℥ii; of this I commence with from 4 to 6 drops every two hours, and increase 1 drop at each dose until the desired result is attained. Should nausea or depression occur I direct a stimulant to be given and the dose lessened for a time, to be again increased as before, as soon as the depression wears off. Thus I continue the remedy so long as the pulse and temperature are above the normal. If given according to this plan, age offers no contra-indication. I give it to infants and to those advanced in years, the dose being modified to suit the age. With this I use hot external applications.

At the beginning of the third stage the veratum is superseded by carbonate or muriate of ammonia, as indicated.

Due attention must be paid to the nourishment; such food be given as will nourish and not offend the digestive organs.

I have never had reason to regret having pursued this plan of treatment, the result of which has been most satisfactory.

If commenced early and in the manner described, it lessens the frequency and force of the heart's action, diminishes arterial tension relieves the skin, lowers the temperature, and soothes the agitation of the nervous system, thereby limiting the duration of the disease, and places the patient in the best possible condition for a favorable recovery.

Selected Article.

INTERNATIONAL MEDICAL CONGRESS,*

NINTH SESSION TO BE HELD IN WASHINGTON, D. C., IN 1887.

RULES AND PRELIMINARY ORGANIZATION.

WASHINGTON, D. C.
March 24, 1885.

The following Rules and Provisional Lists of Officers of the Ninth International Medical Congress, to be held in Washington, in 1887, is published by order of the Executive Committee.

JOHN S. BILLINGS,
Secretary General.

RULES.

1. The Congress will be composed of members of the regular medical profession, and of such persons as may be specially designated by the Executive Committee, who shall have inscribed their names on the Register of the Congress, and shall have taken out their tickets of admission. As regards Foreign members, the above conditions are the only ones which it seems at present, expedient to impose.

The American members of the Congress shall be appointed by the American Medical Association, by regularly organized State and local medical societies, and also by such general organizations relating to special departments and purposes, as the American Academy of Medicine, the American Surgical Association, the American Gynæcological, Ophthalmological, Otological, Larynological, Neurological, and Dermatological Societies, and the American Public Health Association; each of the foregoing Societies being entitled to appoint one delegate for every ten of their members.

The members of all special and subordinate Committees, appointed by the General Committee, shall also be entitled to membership in the Congress.

*The Rules and Preliminary Organization of the Ninth Session of the International Medical Congress, to be held in Washington, D. C., in 1887, will be read with interest by the American profession. As it may prove useful for reference and for other purposes, it is thought best to publish it in full in the JOURNAL at this time.—EDITORS.

All Societies entitled to representation are requested to elect their Delegates at their last regular meeting preceding the meeting of the Congress, and to furnish the Secretary-General with a certified list of the Delegates so appointed.

2. The work of the Congress is divided into nineteen Sections, as follows, viz.:

1. Medical Education, Legislation, and Registration, including methods of teaching, and buildings, apparatus, &c., connected therewith.
2. Anatomy.
3. Physiology.
4. Pathology.
5. Medicine.
6. Surgery.
7. Obstetrics.
8. Gynæcology.
9. Ophthalmology.
10. Otology.
11. Dermatology and Syphilis.
12. Nervous diseases and Psychiatry.
13. Laryngology.
14. Public and International Hygiene.
15. Collective Investigation, Nomenclature, and Vital Statistics.
16. Military and Naval Surgery and Medicine.
17. Practical and Experimental Therapeutics.
18. Diseases of Children.
19. Dental and Oral Surgery.

3. The General Meetings will be reserved for the transaction of the general business of the Congress, and for addresses or communications of scientific interest more general than those given in the Sections.

4. Questions which have been agreed upon for discussion in the Sections shall be introduced by members previously nominated by the Officers of the Section. The members who open discussions shall pre sent, in advance, a statement of the conclusions which they have formed as a basis for debate.

5. Notices of papers to be read in any of the Sections, together with abstracts of the same, must be sent to the Secretary of that Section before April 30, 1887. These abstracts will be regarded as confidential communications, and will not be published until the meeting of the Congress. Papers relating to questions not included in the list of subjects suggested by the Officers of the various Sections will be received. Any member, after April 30, wishing to bring forward a subject not upon the programme, must give notice of his intention to the Secretary-General at least twenty-one days before the opening of the Congress. The Officers of each Section shall decide as to the acceptance of any communication offered to their Section, and shall fix the time of its presentation. No communication will be received which has been already published, or read before a Society.

6. All addresses and papers, read either at General Meetings or in the Sections, are to be immediately handed to the Secretaries. The Executive Committee, after the conclusion of the Congress, shall proceed with the publication of the Transactions, and shall have full power to decide which papers shall be published, and whether in whole or in part.

7. The official languages are English, French, and German.

In the Sections no speaker will be allowed more than ten minutes, with the exception of readers of papers and those who introduce debates, who may occupy twenty minutes.

8. The Rules, Programmes,and Abstracts of Papers will be published in English, French, and German.

Each paper or address will appear in the Transactions in the language in which it was delivered by the author. The debates will be printed in English.

9. The Officers of the General Committee on Organization are a President, such number of Vice-Presidents as may hereafter be determined on, a Secretary-General, and a Treasurer, and those elected to these positions will be nominated by the General Committee to hold the same offices in the Congress. All vacancies in these offices shall be filled by election. Honorary Presidents of the Congress and of the several Sections may be appointed at the meeting of the Congress.

10. There shall be an Executive Committee, to be composed of the President, Secretary-General, and Treasurer of the General Committee, the Chairman of the Finance Committee, and of four other members o be elected by the General Committee. The duties of the Executive Committee shall be to carry out the directions of the General Committee, to authorize such expenditures as may be necessary, and to act for the General Committee during the intervals of its sessions, reporting such action at

the next meeting of the General Committee.

11. There shall be a Standing Committee on Finance, composed of such number of persons as the Executive Committee may deem expedient, to be appointed by the President, subject to the approval of the Executive Committee. The Chairman of the Finance Committee shall be *ex officio* one of the Vice-Presidents of the Congress, and also a member of the General and Executive Committees. The Treasurer shall be *ex officio* a member of the Finance Committee.

12. Presidents of the Sections shall be *ex officio* members of the General Committee.

13. The Committee on Organization of each Section shall be composed of a President, such number of Vice-Presidents as may be deemed expedient, of one or more Secretaries, and of members forming a council.

PRELIMINARY ORGANIZATION.

President—Dr. Austin Flint, Sr., New York.

Vice-Presidents—Drs. Henry I. Bowditch, Boston; Henry F. Campbell, Augusta, Ga.; Nathan S. Davis, LL.D., Chicago; R. Palmer Howard, Montreal; Levi C. Lane, San Francisco; Tobias G. Richardson, New Orleans; Alfred Stille, LL.D., Philadelphia; The Chairman of the Committee on Finance; The President of the American Medical Association; The Surgeon-General of the United States Army; The Surgeon-General of the United States Navy.

Secretary-General—Dr. John S. Billings, LL.D., U. S. A., Washington.

Treasurer—Dr. John Mills, U. S. N., Washington.

General Committee—Drs. Robert Battey, Rome, Ga.; Clarence J. Blake, Boston; Henry P. Bowditch, Boston; Samuel C Busey, Washington; James R. Chadwick, Boston; J. M. Da Costa, Philadelphia; John C. Dalton, New York; W. W. Dawson, Cincinnati; Francis Delafield, New York; George J. Engelmann, St. Louis; I. Minis Hays, Philadelphia; David L. Huntington, U. S. Army, Washington; Abraham Jacobi, New York; Hosmer A. Johnson, LL.D., Chicago; Christopher Johnston, Baltimore; R. A. Kinloch, Charleston, S. C.; George M. Lefferts, New York; Jos. Leidy, LL.D., Philadelphia; S. Weir Mitchell, Philadelphia; Henry D. Noyes, New York; Thaddeus A. Reamy, Cincinnati; Thomas F. Rochester, Buffalo; Lewis A. Sayre, New York; Jonathan Taft, Cincinnati; W. Chew Van Bibber, Baltimore; Horatio C. Wood, Philadelphia; David W. Yandell, Louisville, Ky.

Executive Committee—Dr. I. Minis Hays, Chairman, Philadelphia; The President; The Secretary-General; The Treasurer; The Chairman of the Finance Committee; Drs. Samuel C. Busey, Washington; Abraham Jacobi, New York; Christopher Johnston, Baltimore.

Standing Committee on Finance—Dr. Wm. Pepper, LL.D., Chairman, Phila.

[The organization of this Committee will be announced hereafter.]

Section 1—Medical Education, Legislation, and Registration.

President—Dr. Henry P. Bowditch, Bost.

Vice-Presidents—Drs. Stanford E. Chaillé, New Orleans; Alfred Stillé, LL.D., Philadelphia.

Secretaries—Drs. Sam'l J. Mixter, Boston; Wm. P. Whitney, Boston.

Council—Drs. Nathan S. Davis, LL.D., Chicago; Henry D. Didama, Syracuse, N. Y.; Henry Gibbons, San Francisco; Daniel C. Gilman, LL.D., President Johns Hopkins University, Baltimore; James F. Harrison, University of Virginia; Charles A. Lindsley, New Haven, Conn.; Wm. Pepper, LL.D., Philadelphia; J. F. Prioleau, Charleston, S. C.; John H. Rauch, Springfield, Ill.; L. McLane Tiffany, Baltimore.

Section 2—Anatomy.

President—Dr. Joseph Leidy, LL.D., Philadelphia.

Vice-President—Dr. Samuel Logan, New Orleans.

Secretaries—Drs. William W. Keen, Philadelphia; George E. DeSchweinitz, Phila.

Council—Drs. Harrison Allen, Philadelphia; Frank Baker, Washington; Thomas Dwight, Boston; Francis L. Parker, Charleston, S. C.; Charles T. Parkes, Chicago; Thomas T. Sabine, New York; Nicholas Senn, Milwaukee; Francis J. Shepherd, Montreal; Robert W. Shufeldt, U. S. Army; Burt G. Wilder, Ithaca, N. Y.

Section 3—Physiology.

President—Dr. John C. Dalton, New York.

Vice-Presidents—Drs. Jas. F. Hibberd, Richmond, Ind.; H. Newell Martin, Baltimore; Middleton Michel, Charleston, S. C.

Secretary—Dr. John C. Curtis, New York.

Council—Drs. G. Baumgarten, St. Louis; Henry G. Beyer, U. S. Navy; Henry P. Bowditch, Boston; Henry F. Campbell, Augusta, Ga.; Austin Flint, Jr., New York; William Lee, Washington; John J. Mason, Newport, R. I.; S. Weir Mitchell, Philadelphia; Henry Sewall, Ann Arbor, Mich.

Section 4—Pathology.

President—Dr. Francis Delafield, New York.

Vice-President—Dr. William Pepper, LL.D., Philadelphia.

Secretaries—Drs. Theophile M. Prudden, New York; William H. Welch, Baltimore.

Council—Drs. Christian Fenger, Chicago; Reginald H. Fitz, Boston; Edward G. Janeway, New York; James B. Johnson, St. Louis; Thomas E. Satterthwaite, New York; George M. Sternberg, U. S. Army; James Tyson, Philadelphia; William F. Whitney, Boston.

Section 5—Medicine.

President—Dr. J. M. Da Costa, Phila.

Vice-Presidents—Drs. Alfred L. Loomis, LL.D., New York; James B. McCaw, Richmond, Va.; Richard McSherry, Baltimore; Alonzo B. Palmer, LL.D., Ann Arbor, Mich.; Thomas F. Rochester, Buffalo.

Secretary—Dr. William Osler, Phila.

Council—Drs. Samuel C. Chew, Baltimore; William H. Draper, New York, William H. Geddings, Aiken, S. C.; William W. Johnson, Washington; George A. Ketchum, Mobile; Francis Minot, Boston; William Pepper, LL.D., Philadelphia; Beverly Robinson, New York; Andrew H. Smith, New York; James T. Whittaker, Cincinnati.

Section 6—Surgery.

President—Dr. David W. Yandell, Louisville.

Vice-Presidents—Drs. D. Hayes Agnew, LL.D., Philadelphia; William T. Briggs, Nashville; Samuel W. Gross, Philadelphia; W. H. Hingston, Montreal; R. A. Kinloch, Charleston, S. C.; Edward M. Moore, Rochester, New York; Lewis A. Sayre, New York.

Secretary—Dr. John Collins Warren, Boston.

Council—Drs. John Ashhurst, Jr., Philadelphia; David W. Cheever, Boston; Phineas S. Conner, Cincinnati; W. W. Dawson, Cincinnati; George E. Fenwick, Montreal; Frederic H. Gerrish, Portland, Me.; J. C. Hutchison, Brooklyn; Christopher Johnston, Baltimore; Levi C. Lane, San Francisco; Thomas M. Markoe, New York; Alan P. Smith, Baltimore; J. Ford Thompson, Washington; Theodore R. Varick, Jersey City; Samuel B. Ward, Albany, New York; Robert F. Weir, New York.

Section 7—Obstetrics.

President—Thaddeus A. Reamy, Cincinnati.

Vice-Presidents—Drs. William T. Howard, Baltimore; R. B. Maury, Memphis; John C. Reeve, Dayton, Ohio. Albert H. Smith, Philadelphia.

Secretary—Dr. Paul F. Munde, New York.

Council—Drs. Robert P. Harris, Philadelphia; Alfred F. A. King, Washington; William T. Lusk, New York; Matthew D. Mann, Buffalo; Theophilus Parvin, Philadelphia; John Scott, San Francisco.

Section 8—Gynecology.

President—Dr. Robert Battey, Rome, Ga.

Vice-Presidents—Drs. William H. Byford, Chicago; Thomas Addis Emmet, New York; Henry P. C. Wilson, Baltimore.

Secretaries—Drs. James R. Chadwick, Boston; George J. Engelmann, St. Louis.

Council—Drs. William H. Baker, Boston; William Gardner, Montreal; William Goodell, Philadelphia; A. Reeves Jackson, Chicago; J. Taber Johnson, Washington; George H. Lyman, Boston; Emil Noeggerath, New York; T. Gaillard Thomas, New York; Ely Van De Warker, Syracuse, New York.

Section 9—Ophthalmology.

President—Dr. Henry D. Noyes, New York.

Vice-President—Drs. William Thomson, Philadelphia; E. Williams, Cincinnati.

Secretary to be announced hereafter.

Council—Drs. Cornelius B. Agnew, New

York; Charles S. Bull, New York; Swan M. Burnett, Washington; A. W. Calhoun, Atlanta, Ga.; Hasket Derby, Boston; Samuel J. Jones, Chicago; Herman Knapp, New York; Edward G. Loring, New York; William F. Norris, Philadelphia; W. W. Seely, Cincinnati; Samuel Theobald, Baltimore; Oliver F. Wadsworth, Boston; Henry W. Williams, Boston.

Section 10—Otology.

President—Dr. Clarence J. Blake, Boston.
Vice-Presidents—Drs. Charles H. Burnett, Philadelphia; H. N. Spencer, St. Louis.
Secretary to be announced hereafter.
Council—Drs. Albert H. Buck, New York; John Green, St. Louis; J. Orne Green, Boston; Stephen O. Richey, Washington; Daniel B. St. John Roosa, LL.D., New York; Samuel Sexton, New York; George Strawbridge, Philadelphia.

Section 11—Dermatology and Syphilis.

President—Dr. Willam A. Hardaway, St. Louis.
Vice-Presidents—Drs. Louis A. Duhring, Philadelphia; James Nevins Hyde, Chicago; James C. White, Boston.
Secretary—Dr. Arthur Van Harlingen, Philadelphia.
Council—Drs. I. Edmondson Atkinson Baltimore; L. Duncan Bulkley, New York; Edward L. Keyes, New York; Fessenden N. Otis, New York; Robert W. Taylor, New York; Edward Wigglesworth, Boston; Henry C. Yarrow, Washington.

Section 12—Nervous Diseases and Psychiatry.

President—Dr. S. Wier Mitchell, Phila.
Vice-Presidents—Drs. Charles F. Folsom Boston; John P. Gray, LL.D., Albany, N. Y.; J. S. Jewell, Chicago.
Secretary—Dr. Charles K. Mills, Phila.
Council—Drs. Roberts Bartholow, LL.D. Philadelphia; Allan McLane Hamilton, New York; Walter Hay, LL.D., Chicago; Francis T. Miles, Baltimore; James J. Putnam, Boston; Samuel G. Webber, Boston; Horatio C. Wood, Philadelphia; John P. Van Bibber, Baltimore.

Section 13—Laryngology.

President—Dr. George M. Lefferts, New York.
Vice-President—Dr. Frederick I. Knight, Boston.
Secretary—Dr. D. Bryson Delavan, New York.
Council—Drs. F. H. Bosworth, New York; William H. Daly, Pittsburg; E. Fletcher Ingals, Chicago; J. N. Mackenzie, Baltimore; George W. Major, Montreal; E. Carroll Morgan, Washington; William Porter, St. Louis; E. L. Shurley, Detroit, Mich.

Section 14—Public and International Hygiene.

President—Dr. Hosmer A. Johnson, LL.D., Chicago.
Vice-Presidents—Drs. Ezra M. Hunt, Trenton, N. J.; John Berrien Lindsley, LL.D., Nashville; James E. Reeves, Wheeling, W. Va.
Secretary to be announced hereafter.
Council—Drs. Henry B. Baker, Lansing, Mich.; Alfred L. Carroll, Albany, N. Y.; Granville P. Conn, Concord, N. H.; William H. Ford, Philadelphia; Daniel W. Hand, St. Paul; Jerome H. Kidder, Washington; Charles A. Lindsley, New Haven, Conn.; J. N. McCormick, Bowling Green, Ky.; J. H. Rauch, Springfield, Ill.; Joseph H. Raymond, Brooklyn, N. Y.; Joseph R. Smith, U. S. Army; Stephen Smith, New York; S. O. Van Der Poel, LL.D., New York; H. P. Wolcott, Cambridge, Mass.

Section 15—Collective Investigation, Nomenclature and Vital Statistics.

President—Dr. Nathan S. Davis, LL.D., Chicago.
Vice-Presidents—Drs. Jerome Cochran, Mobile; Edwin M. Snow, Providence, R. I.
Secretary—Dr. James F. Todd, Chicago.
Council—Drs. Nathan Allen, Lowell, Mass.; Richard A. Cleeman, Philadelphia; J. H. Hollister, Chicago; Abraham Jacobi, New York; James T. Reeve, Appleton, Wis.; James Tyson, Philadelphia.

Section 16—Military and Naval Surgery and Medicine.

President—Drs. David L. Huntington, U. S. Army.
Vice-Presidents—Drs. Frank H. Hamilton, LL.D., New York; Hunter McGuire, Richmond, Va.; S. P. Moore, Richmond, Va.; William E. Taylor, U.S. Navy, (retired)
Secretary—Dr. Benjamin F. Pope, U. S. Army.

Council—Drs. Edmund Andrews, Chicago; Delavan Bloodgood, U. S. Navy; R. B. Bontecou, Troy, N. Y.; John H. Brinton, Philadelphia; Julian J. Chisolm, Balmore; P. O. Hooper, Little Rock, Ark.; E. J. Marsh, Patterson, N. J.; Claudius H. Mastin, Mobile; George Peck, U. S. Navy, W. F. Peck, Davenport, Iowa; Charles Smart, U. S. Army; J. Rufus Tyson, U. S. Navy; Alfred Woodhull, U. S. Army.

Section 17—Practical and Experimental Therapeutics.

President—Dr. Horatio C. Wood, Phila.
Vice-Presidents—Robert T. Edes, Boston; R. Peyre Porcher, Charleston, S. C.
Secretaries—Drs. Edward T. Reichert, Philadelphia; Robert Meade Smith, Phila.
Council—Drs. Robert Armory, Boston; Edward Curtis, New York; Laurence Johnson, New York; Henry M. Lyman, Chicago; Samuel Nickels, Cincinnati; Isaac Ott, Easton, Pa.; Daniel Webster Prentiss, Washington; Charles Rice, New York; Charles H. White, U. S. Navy; Thomas F. Wood, Wilmington, N. C.

Section 18—Diseases of Children.

President—Dr. Abraham Jacobi, New York.
Vice-Presidents—Drs. Samuel C. Busey, Washington; J. Lewis Smith, New York.
Secretary—Dr. Thos. M. Rotch, Boston.
Council—Drs. F. Forchheimer, Cincinnati; John M. Keating, Philadelphia; Wm. Lee, Baltimore; John H. Pope, Marshall, Texas; John H. Ripley, New York.

Section 19—Dental and Oral Surgery.

President—Dr. Jonathan Taft, Cincinnati.
Vice-Presidents—Drs. W. W. Allport, Chicago; William H. Dwinelle, New York; Jacob L. Williams, Boston.
Secretaries—Drs. Edward A. Bogue, New York; George H. Cushing, Chicago.
Council—Drs. W. C. Barrett, Buffalo; Thomas Fillebrown, Boston; F. J. S. Gorgas, Baltimore; Edward Maynard, Washington; H. J. McKellops, D. D. S., St. Louis; W. H. Morgan, Nashville; C. Newlin Peirce, D. D. S., Philadelphia; L. D. Shepherd, D. D. S., Boston; James Truman, D. D. S., Philadelphia; J. W. White, Philadelphia.

Society Reports.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

STATED MEETING THURSDAY, MARCH 12, 1885.

The President, Dr. Shakespeare, in the Chair.

Dr. Thos. J. Dunn, of West Chester, presented

A CASE OF INTESTINAL OCCLUSION.

Eliza Hazzard, colored, aged 57, sent for me August 1st. She was suffering from an attack of diarrhœa, with some pain, vomiting and epigastric tenderness. Morphia, a powder of bicarb. of soda, ipecac and calomel, and externally a mustard plaster and large mush poultice were prescribed. The day following her condition was much improved, though the pulse was still weak and rapid, and tongue heavily coated. The temperature was not elevated. She was given a prescription of aromatic spirits of ammonia, wine of ipecac and muriate of ammonia, to be taken every two hours, and tea and milk. The next day she was seized with violent pain and cramps, and vomiting, rapidly sank and died twelve hours afterwards.

Directions were left to send for me, if the patient was not doing well, the day after I saw her, but hoping to secure relief by use of domestic remedies, the message was not received by me in time to reach her before death. She was subject to violent attacks of indigestion, for which I had frequently attended her.

Autopsy fifty hours after death.—The body was very thin and badly nourished; no jaundice. *Pleura* slightly adherent over posterior portion of the right side. *Lungs* highly pigmented. *Heart* somewhat hypertrophied; no valvular disease. *Spleen* atrophied and adherent to left lobe of liver, which was drawn to the left side. The *liver* was also extensively adherent to omentum and diaphragm, otherwise healthy. *Stomach* and *intestines* distended with gas, the mucous surfaces injected. A knuckle of about 8 inches of the ileum, near the ileo-cæcal valve, was strangulated and was very dark and inflamed. The inflammation extended to other portions of the gut, and some lymph had been thrown out. The portion stran

gulated had passed through the broad ligament of left side and had twisted upon itself. The round ligament served as a cord, which tightly constricted it. The peritoneal covering of the uterus, broad ligament and pelvic walls was thickened and very rough. I think the accident can be accounted for by supposing that the peritonitis had been quite extensive, and had resulted in perforation of the broad ligament of the left side. The peristalsis accompanying the several loose movements of the bowels, probably led to a hernia of the knuckle of intestine and its subsequent twisting and strangulation. The condition of the patient when last seen, thirty-six hours before death, was so greatly improved from that of the previous day, that the diagnosis of an attack of indigestion was confirmed. Had she been seen the third, when the pain, vomiting and cramps returned, and intestinal strangulation recognized, the case would have been a favorable one for laparotomy.

Dr. Nancrede said that he felt satisfied that the band was due to old peritonitis, and not to a slit in the broad ligament, giving numerous anatomical and pathological reasons for his opinion.

Dr. H. M. Fisher presented a

HEART FROM A CASE OF PHTHISIS, WITH MITRAL INCOMPETENCY.

Sarah B., æt 36, was admitted to the Episcopal Hospital February 6, 1885. The following notes of the case were furnished me by Dr. O. Hopkinson, Jr., the resident physician. Patient has had eight children, and menstruation was regularly performed till about Christmas, when it ceased. Since then she has suffered somewhat from leucorrhœa and painful micturition. None of patient's immediate family appear to have been phthisical, but she herself has never been very strong, and has had slight cough for about a year. The cough has been more troublesome for about six weeks, and six days before admission she coughed up about "a cupful of blood," and had another hemorrhage two days before admission. She was pale, and had a yellowish, earthy hue, and was markedly pigeon-breasted. Her heart appeared hypertrophied, but the extent of the hypertrophy could not very easily be determined on account of the deformity of the chest. The first mitral sound was thin and the second accentuated, but when I first examined her I was unable to detect a murmur at the apex. There was increased percussion resistance over the apices of both lungs; expiration slightly prolonged, and subcrepitant râles under left clavicle after coughing; fine crackling heard also over upper half of right lung. Ordered elixir ferri, quinia et strychnia ℥ i, t. d. Expectoration is scanty and cough not very troublesome. Feb. 20th: A systolic pulsation noticed this morning in left external jugular; apex systolic murmur not very clearly transmitted to axilla; the first aortic sound is rather indistinct; the second pulmonary sound accentuated; impairment of resonance over bases of both lungs; the percussion note over base of right lung being almost flat, and breath sound here very feeble; patient's bladder is very much distended and almost complete retention of urine since yesterday evening; urine slightly albuminous, and microscope shows pus cells and triple phosphates in abundance, but no casts. Ordered tinct. digitalis gtt. xxx, twice daily, and tr. hyoscyam. m. x, spir. ether, nitrat. ℥ i., potass. citrat. grs. xv., mist. acac. q. s. ad ℥ ss. three or four times a day.

Feb. 21. Patient had an epileptiform convulsion this evening, which lasted about 15 minutes, and she remained unconscious about 5 minutes after convulsive movements had ceased. This was neither preceded nor followed by vomiting.

Feb. 22. I found patient conscious and complaining of no pain or headache. She had had another convulsion at 6 A. M.

Feb. 23. After being catherized this morning had another convulsion. Respiration 13; there is a pause of two or three seconds at the end of each expiration; no paralysis; can be roused, but is decidedly apathetic.

Feb. 24. Died this morning in a comatose condition. Post-mortem examination 4 hours after death. *Head*, pia-mater everywhere much injected, with subarachnoidal effusion or lymph, most marked over left superior lobule; lymph channels generally opaque; slight capillary hemorrhages in substance of pia, one of the most marked of which is just anterior to fissure of Rolando on left side.

Thorax. Both *lungs* show old adhesions, those on the right side being most firm;

cheesy nodules surrounding thickened bronchi in upper lobe of both lungs, with catarrhal pneumonia patches disseminated through both lungs.

Pericardium contained about an ounce of opaque straw-colored fluid.

Heart—R. ventricle contains black fluid blood. R. auricle also.

L. ventricle empty, and its walls are about an inch in thickness. Auricle contains fluid blood.

The arterial leaflets are somewhat thickened and rigid, and the valve is not absolutely competent.

The mitral leaflets are much thickened, particularly the posterior leaflet, which is somewhat adherent to the ventricular wall, and would necessarily have rendered valve incompetent.

Dr. H. M. Fisher presented

ORGANS FROM A CASE OF PARENCHYMATOUS NEPHRITIS, WHICH WAS ACCOMPANIED BY INTESTINAL ULCERATION AND PELVIC ABSCESS.

Elizabeth H., æt. 32, widow, colored, was admitted to the Episcopal Hospital, February 17th, 1885. I am indebted to the resident physician, Dr. O. Hopkinson, Jr., for the following notes of the case.

She has had three children. Menstruation was regularly performed until one year ago, when it appears to have ceased. The patient's mind was very dull and it was with difficulty that any facts were elicited from her with regard to her previous condition of health. She had been able to work until one month ago, when she was suddenly seized with great weakness, diarrhœa, and high fever, followed by profuse sweating, which prostrated her and left her helpless. Upon admission, she was found to be extremely weak. There is motor paralysis of the left arm and partial paralysis of the left leg. No facial paralysis was noticed and no strabismus. There is pretty general anasarca, but the œdema is most noticeable in the dependent portions of the body, such as the left arm and leg, the patient lying chiefly upon her left side. There is much diarrhœa and the passages are very offensive. There is also a very profuse greenish-white vaginal discharge.

The tongue is clean, the abdomen tympanitic; hepatic dulness begins in the fourth interspace in the mammary line and extends to the seventh rib. There is a faint basic systolic murmur audible. At the apex the first sound has a flapping character. The urine is pale; has a sp. gr. of 1008 and contains albumen in considerable quantity. Under the microscope fatty and granular casts and pus cells are seen. During the remainder of the time she remained under observation (about ten days) her condition changed very little. The diarrhœa was held in check to a certain extent by astringents, though she still continued to have two or three large, watery, blackish stools daily. The day before her death I noticed a double basic as well as a double mitral murmur. She died, and it was noticed that her heart continued to beat fifteen minutes after all signs of respiration had ceased. She had been taking for twenty-four hours tr. digitalis, gtt. xxxv, every four hours, which may, perhaps, have induced this result.

Post-mortem examination thirty-six hours after death. The skull is very thick, measuring $\frac{7}{16}$ inch in the frontal and $\frac{1}{2}$ inch in the occipital region. The veins are very much enlarged and there are some capillary hemorrhages in the pia; the left lateral ventricle contains $\frac{1}{2}$ drachm of bloody serum. No clot or embolus detected.

Right pleural cavity contained 6 fluid-drachms of clear serum, the right still less.

Lungs.—Lower halves of all lobes show intense congestion and upper portions free (hypostatic). The crepitate throughout.

Heart.—Pericardial cavity contains about $\frac{1}{2}$ ounce of clear serum. White, firm fibrinous patch of the size of a dime at apex of heart. R. auricle contains large chicken fat clot, and much dilated, and there is a clot adherent to tricuspid valve. The r. ventricle is also somewhat dilated. The l. ventricle contains black fluid blood. The mitral valve admits two fingers easily appears by hydrostatic test to be not thoroughly competent. The aortic valve is not competent and its leaflets are thickened. The aortic appears also thickened and atheromatous. Apparently some marks of congestion of endocardium at valvular orifices, but no vegetations anywhere seen. Heart muscle soft, possibly partly in consequence of commencing decomposition.

Subcutaneous fat of abdomen about one-half inch thick. Omentum and mesentery are also loaded with fat. *No peritoneal adhesions* anywhere visible in the upper portion of the abdominal cavity.

Small intestine shows throughout its entire extent very decided hyperæmia, and is filled with black fluid fæcal matter.

The ileum is of a reddish-brown hue and shows intense congestion, and about three feet from the ileo-cæcal valve there are several irregular ulcers extending down to the muscular layer. There are clots still adherent to the surface of several of these ulcers. The largest of the ulcers are about half an inch in height; there are also numerous minute round ulcerations.

Peyer's patches and other solitary glands do not appear to be involved in the ulceration present; nor is there any marked involvement in the mesenteric glands. The mucous membrane of the ileum is roughened and loaded.

The *right kidney* weighs 8½ ounces; its capsule is non-adherent. Upon section the cortex and the medullary portions have about normal relations as to thickness, but the tissues are of a dull, yellowish-white hue, to which the pinkish hue of the pyramids stands out in marked contrast.

The *left kidney* weighs 7½ ounces and presents the same morbid appearance.

The *stomach* shows no marked pathological changes.

The *spleen* weighs only 3½ ounces, and seems unusually firm and dry.

The *liver* appears rather larger than normal, pale and apparently fatty and shows areas of congestion. In none of these organs are any infarctions visible.

The *uterus and vagina* show intense congestion of their mucous lining. The uterine cavity is markedly dilated and filled with creamy pus. Behind the left broad ligament an encysted collection of pus is seen, which appears to have been formed in a pouch of the Fallopian tube (pyo-salpinx). Both ovaries and Fallopian tubes are enveloped in false membranes and the uterus is adherent to the bladder and the rectum through pseudo-membranous exudations.

This case presents, I think, many interesting points for study. Bartels, in Ziemssen's Cyclopædia, refers to intestinal ulcerations occurring in the course of parenchymatous nephritis as a consequence of the œdema of the submucous layer of the intestine. In this case, however, I was unable to detect any œdema of the intestinal parietes; the mucous membrane looked rather as if it had been acted upon by some corrosive poison. This ulceration might, I think, be due to the general atheromatous condition of the arterial system, the irritant in this case being perhaps an accumulation of effete products (urinary salts?) in the blood. The question also naturally arises whether this ulceration might not have been due to septic infarctions originating from the purulent focus in the pelvic peritoneum.

Opposed to this view of the case was the absence of general peritonitis and the absence of splenic changes pointing to a septicæmic process; the absence, too, of any apparent infarctions of other organs. Though this was an obscure history of previous pelvic attack the patient's temperature was normal or subnormal while in the hospital. The hemiplegia was undoubtedly due to the plugging of one of the cerebral vessels, as no clot was found in the brain, and a more careful examination would probably have revealed such an embolus.

Carbonate of Ammonia in Scarlet Fever.—Dr. A. W. Jackson, of Brooklyn, writes to the *Med. Record*, calling attention to the treatment of scarlatina first brought prominently into notice by Dr. Peart, of England. This consists in the administration of from three to seven grains of carbonate of ammonia every hour for the first day, and then at longer intervals. Purgatives are to be avoided during the early stages of the disease. The writer states that he has had occasion to test this mode of treatment, and can endorse it heartily. In addition he employs the fluid extract of eucalyptus internally and as a gargle. When there is much exudation a mixture of carbolic acid and iodine in glycerine is painted over the parts. In too rapid recession of the rash, Dr. Jackson applies cloths dipped in thick mustard water, or wraps the child in blankets wrung out in hot water.

Pepsin as a Solvent of Blood-Clots in the Bladder.—The editor of the *Northwestern Lancet* calls attention to a novel use of pepsin in surgery. In a case of distended bladder, when clotted blood prevented evacuation, he dissolved a scruple of Jensen's crystal pepsin in an ounce of warm water, and in less than twenty minutes had the satisfaction of seeing the patient pass a full stream of urine and disintegrated blood.

PROCEEDINGS OF THE MEDICAL SOCIETY, DISTRICT OF COLUMBIA.

STATED MEETING HELD FEB. 4TH, 1885.

(*Specially Reported for the Md. Med. Journ.*).

The Society met with the President, DR. W. W. JOHNSTON, in the chair, DR. MCARDLE, Secretary.

Dr. O. M. Muncaster said: "I would report for your consideration this evening

TWO CASES OF INFLAMMATION OF THE MIDDLE EAR,

extending to the brain. One originating in an attack of scarlet fever, and the other caused by sympathetic irritation proceeding from a tooth the child was cutting. Cases of this kind are often overlooked, and the disease considered one of the brain alone, on account of the serious symptoms of the latter.

Four years ago I was called to see a little boy, aged ten years, who had inflammation of the middle ear, and loss of the tympanum, from a severe attack of scarlet fever when he was six years old. This had been allowed to run on without treatment to the time of my visit. When in the height of the fever, he had grave head symptoms, which were only relieved by a sudden discharge from his ear. I found, on examination, a chronic inflammation of the middle ear, with granulations, and copious purulent discharge. I treated him with washes of a solution of sulphate of zinc, applied a strong solution of nitrate of silver to the granulations, and gave insufflations of powdered alum. There was marked improvement, but having several returns of the discharge from severe colds, his father took him to an aurist, who treated him with insufflations through the Eustachian catheter of air medicated with iodine. This was kept up for about six months, until the discharge had almost ceased. I was called to see him in great haste, and found him suffering with intense headache and high fever, and just recovering from a severe chill. Thinking it a malarious attack, I ordered a solution of bromide of potassium for his head, and quinine pills. Calling to see him in the afternoon, I found him very much jaundiced, with high fever and great nausea. He had taken the bromide mixture, but not the quinine. He still had severe headache. I ordered a purgative of colomel and Rochelle salts, and the elixir of bromide of quinine. The next morning he had another severe chill, with increased headache, nausea and jaundice, but never complained of pain in his ear. After the purgative acted, and he had taken three doses of the elixir, he got much more comfortable, but the next morning he had a chill, and all his symptoms were so aggravated, that I asked for a consulting physician; but before he saw him with me that afternoon, there was a copious discharge of blood and pus from his ear, that was so offensive it was almost unbearable. There was no swelling or tenderness on pressure over the mastoid cells, and on examination, I could discover no carious bone. The child's condition was such, that I could not examine his ear well enough to find the exact source of the discharge. He soon became comotose, and died that evening. I tried very hard to get a post-mortem examination, but the parents would not permit it.

Now, was this inflammation of the ear, chills, jaundice, fever and congestion of the brain caused by an attack of malaria, or was it congestion of the ear from severe cold, with its accompanying sympathetic action in the brain and liver? and would not treatment instituted from the first to allay the congestion of the ear, have altered the final result? Of one thing I do feel certain, and it is this: The whole trouble could have been avoided by proper treatment when the child had scarlet fever, by steaming with unslacked lime, for it reduces the fever and allays the congestion of the ear, throat and nasal passages, as no other treatment will. I have a wooden bucket filled one-quarter full of the lumps of unslacked lime, and placing the child on a high chair, cover it and the bucket with a sheet. Then pouring on the lime enough water to cover it, I let the child remain until it is done slacking. By repeating this every four hours, I have the most encouraging results. The child should be wrapped up well in a blanket, after each steaming, until it cools off.

The other case of which I would speak this evening, was one of convulsions from teething. When I first saw her she was recovering from the third convulsion,

Had high fever, swollen and inflammed gums, and continually rolled its little head from side to side. I lanced its gums, and suspecting ear trouble, went for my speculum, but found, on my return, that the tympanum had ruptured, and that there was quite a discharge of muco-purulent matter. The child was quite relieved, and, with a febrifuge and soothing wash for the ear, soon entirely recovered. Now, how many children, suffering in this way, are treated for sympathetic disease of the brain *alone*, when by timely attention to, or treatment of the ears, great suffering, and often the lives of the little ones could be saved. This can be done by leeching the ear, giving internally tr. of aconite to diminish the heart's action, and by letting a stream of warm water run into the ear at frequent intervals. Woakes calls special attention to the rolling of the child's head from side to side, as a constant and grave symptom of this disease. When there is bulging of the drum-head accompanying this rolling of the head, cry of pain, fever, &c., we should puncture the membrane of the tympanum.

I have here the copy of a cut from Woakes' excellent work on "Deafness, Giddiness, and Noises in the Ears," showing the anatomy of the ear, with its vessels, nerves, ganglion, &c., also the connection of the nerves of the teeth with the otic ganglion by the inferior dental nerve. Irritation from the tooth is conveyed by this nerve to the ganglion, and from it by its vascular nerves to the internal carotid artery and its branch, the tympanic artery. The latter supplying chiefly the drum-head with blood, and being so closely connected with a large arterial trunk, possesses very favorable circumstances for a speedy augmentation of its blood supply, and being connected, as shown above, with the tooth, the source of irritation, the impressions proceeding from the latter and the swollen gums, according to Woakes, excites waves of vessel dilatation in the correlated area and drum-head, causing dilatation of its vessels, congestion, with its attendant stretching of the sensitive and tense tissue, occasioning pain, and if the irritation is sufficiently prolonged, effusion into the tissues, which, under favorable circumstances, will pass on to suppuration and otorrhœa. Owing to the free inosculation of the vessels of the drum-head with those supplying the tympanic cavity, the inflammation is apt to spread to that part, and cause an accumulation of mucus or pus, which, if it does not escape through the Eustachian tube, will bulge the drum-head outwards, producing a state of tension of the endolymph and compression of the fibrillæ of the auditory nerve, producing convulsions, and apart from this pressure, the pain already experienced would give rise to this symptom by the irritation it excites in the sensitive cerebral arteries of the infant.

Politzer and Woakes both show how easily inflammation can extend from the ear of the infant to its brain, by that portion of the dura mater which dips down through the petro-squamosal fissure into the cavity of the tympanum, becoming continuous with its muco-periosteal lining. This process of the dura mater is richly endowed with vessels derived from the middle-meningeal artery. Towards adult life this fissure becomes more or less obliterated, but the vascular connection with the arteries remain. How carefully then we should watch the ear, when the brain symptoms develop in infants suffering with teething or the exanthemata!

Dr. S. O. Richey said he had seen a number of cases similar to the first one described in the paper just read. He thought the greatest source of danger was the burrowing of pus. Sometimes the trouble was due to the extension of inflammation, but he had not seen many such instances. Burrowing was more likely to occur in adults than in children, on account of the greater density of the fibrous tissue in the drum. He knew the rule had been laid down to puncture the tympanum whenever fluid is discovered in the middle ear cavity. It is not always possible, though, to say whether there is or is not fluid in that locality. He thought it wrong to permit discharge from the ear to continue indefinitely; they should be attended to early.

Dr. Ralph Walsh agreed with Dr. Richey that it was a great mistake to allow old discharges from the ear to run on. He attended thirty-three cases which had been permitted to discharge from 5 to 18 years. No cases are so easily cured as these, and none render life so disagreeable. He would not deny, however, that some cases were very stubborn. Early

treatment should be adopted, and he had found nothing better than warmth in the form of vapor, or the use of hot water. He thought the general practitioner did not pay sufficient attention to the special symptoms of ear trouble. They do not attempt to heal the inflammation of these parts.

Dr. Richy believed the general practitioner to-day knew more about these diseases than the specialists of 15 years ago. Patients were formerly advised to let the discharge continue, but it was not so now. He considered the dry treatment the best method of cure. In syringing the force of stream pressure on the drum will increase the pain. When he used warm water he merely filled the extended ear.

Dr. Muncaster thought we should watch our cases, and by relieving congestion prevent rupture of the membrane.

Dr. W. W. Johnston said the paper afforded a good opportunity for the discussion of the treatment of inflammation. In the treatment of ear-ache he had found nothing that would completely relieve the patient. Hot applications gave nothing more than the temporary soothing effect of warmth. He wondered if opium would not be the best remedy. Dr. Richey says it increases the inflammation. He would like to hear the opinions of others relative to the good or bad effects of opiates.

Dr. Walsh agreed with Dr. Richey as to the use of warm water in the ear. He had not, however, found the general practitioner so well informed as Dr. Richey had; for in all his 33 cases the patients had been advised not to stop the discharge. In regard to the treatment of ear-ache, he considered opiates good if the pains were neuralgic. If the pains were due to inflammation, leeches were better than anything else.

Dr. Adams had relieved ear-ache by the application of chloroform on a handkerchief over the mastoid. He had also successfully tried the blowing of chloroform vapor from a saturated piece of absorbent cotton placed in the bowl of a pipe, the stem being put in the ear.

Dr. Hamilton wished members would try cocaine in these cases, and give the results, be they good or bad.

Dr. Richey had recently used a 4 per cent. solution of Merck's preparation in a case to which he was called by Dr. Johnston. He first carefully cleansed the ear, and applied the solution three times, with negative results. The preparation was good, for he had used it in a case of ulceration of the cornea with marked benefit. He had heard before of the application of chloroform, but believed that instead of being a local anæsthetic it was an irritant, and caused increased hyperæmia. Blown against the drum-head it would increase inflammation. The same effect would result from the use of sweet oil and laudanum in the ear. Leeches cannot always be used. Sensitive women and delicate children revolt at the idea.

Dr. Muncaster could not always get leeches of the proper kind when he wanted them. He had found lime vapor the best remedy. He carefully enveloped the child and placed it over slacking lime. He never had any difficulty in repeating the operation.

Dr. Samuel S. Adams said that he could recall an interesting case that he saw at the Children's Hospital some years ago. The patient, J. H. B., colored, male, aged 3 years 3 months, had been treated by Dr. Busey for syphilitic dactylitis, February 26, 1875. Up to this time the patient seemed to be improving in general health. To-day the flexor muscles of the arms and forearms and the extensor of the legs are rigidly contracted; he is semi-comatose, and presented other evidences of cerebral compression. He had had a purulent otitis for sometime, the discharge being profuse until a few days ago, when it almost ceased. Drs. Eliot, Drinkard and Busey met in consultation and decided that the symptoms were due to compression from the pent up pus, and that the proper procedure was to perforate the middle ear from the post-auricular region, thereby making a free exit for the pus in the hope of relieving the urgent symptoms. An anæsthetic was not necessary, as the child was perfectly insensible. Dr. Drinkard made an incision over the mastoid process, intending to trephine, but the bone was so soft that he had no difficulty in cutting his way to the middle ear with his scapel. A free communication was thus established between the auditory canal and the perforation of the mastoid bone. Injections of tepid water were then used, the water passing out at the artificial opening, carrying with it flakes of

pus and dark fœtid matter. Immediate relief followed this operation, the child rallying sufficiently to take nourishment from a spoon, and to notice movements around him. Death took place 30 hours after the operation. He was under the conviction that surgical interference should take place at the first symptom of cerebral compression or irritation. A perforation of the mastoid cells, thorough syringing with an antiseptic fluid and faithful attention, offered many chances to the sufferer, while the "let alone" principle would seal his fate in a short time. He was satisfied this patient would have lived much longer if it had not been for the general purulent infection from multiple abscesses.

On motion the discussion closed, and the Society adjourned.

Editorial.

The Muriate of Cocaine in Intense Pruritus.—The highly flattering reports which have been published in recent journal literature, relative to the value of the muriate of cocaine in pruritus vulvæ, have suggested its use in the intense pruritus of other parts of the body with equal advantage. That we have in this drug a valuable remedy for this distressing and annoying condition the following experience will show:

Mrs. M., married, aged 61, applied to the writer for treatment for intense pruritus in the region of the clitoris and preputial folds. This affection first made its appearance about eighteen months ago and has continued at irregular intervals since that time. The attacks of itching usually make their appearance after the patient has retired to bed and reappear almost every night. Occasionally the attacks have developed during the day. The itching is limited to a circumscribed space not larger than the area of a silver dollar, and always appears at this one spot. It is described as a most intense and distressing affection, of an itching, burning character, which intense rubbing fails to relieve and which has not responded to the many local remedies usually employed for this affection. Coming on at bed-time the pruritus has robbed the patient of refreshing rest and so disturbed natural sleep that its effect is manifest in an impaired condition of general health. The attacks have usually lasted from two to four hours, and have only been partially subdued by local applications of warm water continuously applied for several hours. There is no local inflammation or soreness about the parts, and the severe rubbing has not broken the continuity of the mucous tissue.

It has been stated that this patient has employed the usual astringent and anodyne agents usually used for this affection to no effect. The list of remedies previously employed left nothing to be considered but a four per cent. solution of cocaine. This was ordered. The first application was followed within a very few minutes by immediate relief of the pruritus. The patient dropped off to sleep without experiencing a return of the affection that night. The following night, at the usual bed hour, the pruritus made its return. A second application of the cocaine solution at once lulled the distress, refreshing sleep following. On the third and succeeding nights, up to the time of writing, the history of the first and second nights is repeated.

In the use of the cocaine solution there is then a temporary relief of the distressing symptoms but not a cure of the condition. The relief is, however, so prompt and decided that a nightly recurring symptom is lulled into quietude by an agent which seems to have no other disadvantage than its excessive cost, which renders it a luxury not within the reach of patients with small means. A drachm of a four per cent. solution was consumed by this patient in three nights. It is believed that a larger quantity of the solution was employed than was necessary. It is proposed to employ in future the oleate of cocaine which is a more economical preparation than the watery solution, and the waste in its application is more easily controlled.

The history of this case is offered in this way to suggest the more general use of cocaine in pruritus whether limited to the vulva and rectum, or to hemorrhoidal tumors and other portions of the body similarly affected, especially if this part be a mucous surface.

The International Medical Congress, Ninth Annual Session.—The Rules and Preliminary Organization of the International Medical Congress, Ninth Annual Session, to be held in Washington, D. C., in 1887, have recently been issued by Dr.

John S. Billings, Secretary-General, and the Committee having the Congress in charge. As this meeting of the Congress is one which will be looked forward to with marked interest by the American profession, we have felt that the contents of the pamphlet setting forth the rules and details of the organization of the Congress was of sufficient interest and value to occupy a position in our columns.

Though two years must intervene before the college will again convene, on American soil, the event is of such importance that attention may very properly be directed to it at this time. It will be observed that the preliminary organization is complete in all of its details. The effort which is being made by the friends of the Congress and by the gentlemen entrusted with its successful management seems to us to be one which will bring about a meeting of the greatest im portance and value to the medical profession on this side of the Atlantic. The President, Secretary-General, and the gentlemen selected for the various offices, committees and sections are, with few exceptions, men of national reputation and of distinguished ability. The various appointments have been made carefully and judiciously, and upon the whole seem to us to be in keeping with the high standing and requirements of an International Congress.

The work thus inaugurated commends itself to the American profession, and if the ninth Congress is to reach that high position and influence which is so much to be desired, it behooves the profession to give it an earnest and able support. During the two years which must pass by before the sessions of the Congress convene, an ample opportunity is offered for the preparation of papers of a suitable character for presentation to the various sections of the Congress. It is greatly to be desired that the work presented shall come up to the very highest standard of scientific attainment. The International Congress is not a junketing organization but a body, of scientific workers having in view the development of the highest claims of scientific medicine. In former meetings its work has been of a most respectable character. It rests with the American profession to determine whether the ninth session shall excel or fall below the average reached in former sessions.

A Notice to Subscribers in Arrears to this Journal.—During the past three months bills have been mailed to all subscribers who are in debt to this Journal and to those who owe for the current year. The response to this call has been so illiberal that the proprietor of the Journal is under the painful necessity of urging a prompt remittance from all who are indebted to the Journal for one or more years past. Those who owe for the current year have the privilege of remitting at any time during the year, though advance payments are invited from all who find it convenient to pay in this way. A considerable sum is due from a large number of the Journal's readers, and we trust it will occur to these gentlemen that they are in our debt for its weekly visits and will respond by cancelling this obligation. We have not yet learned the art of conducting a medical publication without labor, paper and ink. To make the machinery of our office run smoothly and regularly we must have the lubricating oil. This can only be supplied by the numerous readers who receive the weekly visits of the Journal. The men who create friction in our work by withholding the lubricating substance are earnestly invited to remedy the injury they are inflicting upon us.

Special Meeting of the Medical and Chirurgical Faculty of Maryland.—A special meeting of the Med. and Chir. Faculty of Maryland was held at the hall, No. 122 W. Fayette St., on Monday last. The object was: 1, to receive charges against certain members of the Faculty who, as is alleged, have been guilty of violating the Code of Ethics by signing a certificate with reference to a secret cough mixture prepared and sold in this city; 2, to make some arrangement by which the annual meeting of the Faculty could be postponed as the regular date conflicts with that of the American Medical Association. The date of meeting being a constitutional requirement, the only thing which could be done was to pass a resolution declaring that it was the wish of the meeting that when the Faculty met April 28th it adjourn without transacting business to May 12th. In accordance with this action it is understood that the annual meeting will be held on the latter date. It will probably be at the Athenæum Building, cor. St. Paul and Saratoga. We may add that

there is some talk of renting the first floor of this building for the uses of the Faculty, which would find there ample facilities for the growth of its library besides superior conveniences in the way of committee, reading and other rooms, all, it is said, at a price within the Society's means. Charges against five gentlemen were duly presented, read and referred without discussion to the Ethics Committee.

We heard of the following as among those proposing to go to New Orleans: Drs. John Morris, John S. Lynch, L. McLane Tiffany, O. J. Coskery, Geo. H. Rohé and John Barron.

Miscellany.

Oleate of Cocaine.—Dr. Chas. J. Lundy, of Detroit, Mich., calls attention, in the *Med. Record*, to the oleate of cocaine as a superior preparation to the muriate. He has conducted numerous experiments with this salt, and has tested its therapeutical value in a number of eye diseases. One advantage is that of economy, as a much smaller quantity may be used, probably because it is not diluted and washed away by the tears. The anæsthetic effect with a five per cent. solution was found to be much greater than with a like quantity of the muriate. Within two minutes after the placing of one drop in the eye, the sensibility of the cornea and conjunctiva was almost entirely abolished, and in three minutes there was absolutely no sensation. With a single drop the period of complete anæsthesia was short—not over seven minutes—and in fifteen minutes sensation was nearly or quite normal. In eight minutes after the instillation of one drop, the pupil was perceptibly enlarged, and in twelve minutes it was widely dilated. In ten minutes there was slight failure of accommodation, but it was at no time very marked. The effects upon the pupil lasted several hours. In experiments in which one drop was placed on the conjunctiva every three minutes for four or five times, a considerable influence was exerted over the ciliary muscle; there was much greater failure of accommodation than the author had ever observed from a very free use of the muriate. The contractile power of the ciliary muscle was completely restored in two or three hours, but the pupil did not return to its normal size, after the instillation of several drops at short intervals, at the expiration of twelve or fifteen hours. The oleate has given great satisfaction also when employed therapeutically. In granular lids with photophobia and blepharospasm, in phlyctenular keratitis, etc., cocaine, and especially the oleate, is a most valuable drug. The oleate is much preferable when there is considerable lachrymation, as an aqueous solution is liable to be washed away before it performs the work required.

Periodical Change of Color of the Hair.—A young girl, æt. 13, of an idiotic type, was admitted into the asylum at Hamburg, April 1, 1880, and died there in 1882. At the age of 3 she began to be affected with spontaneous movements like St. Vitus' dance, chiefly confined to the head and upper limbs. Between 5 and 6 she had become a well-marked epileptic. At 4 she was able to run around a table but her powers of progression steadily diminished and the lower limbs passed into a condition of chronic stiffness. When in the asylum she had fits about every eight to fourteen days; besides, she experienced alternations of agitation and calmness, each of about a week's duration. During agitation the turgescence and redness of the face were most pronounced, the pulse full, skin warm, and actively transposing, at the same time the mental condition being one of extreme obstinacy. It was often remarked that the hair underwent decided changes of color; sometimes it was blonde and at others red, whilst the depth of these colors also varied. The alterations in color occurred in the brief space of two or three days; the first appearance of change was observed at the free ends of the hairs; the same tint of hair persisted for seven or eight days. Each of these periods of change coincided with a phase of agitation or sedateness. During the excitement the hair always had a red color, whilst during the phases of stupidity the blonde tint prevailed. The case appeared to be one of genuine pathological change. The paler hairs differed from the darker ones only in the presence of more numerous air spaces. The structure of brain and spinal cord was much altered.—*Lancet.*

A Portable Transfusion Apparatus.—At the meeting of the British Medical Association, held in Belfast, Dr. Walter

showed in the Obstetric Section a portable transfusion apparatus for defibrinated blood or saline solutions which possesses in a very simple form all the advantages of the more complex apparatuses. It consisted of a glass tube, sufficiently large to hold four ounces of fluid, one end of which is drawn out to a point and connected with a piece of India-rubber tube, which is about the same shape as a small Higginson's syringe. To the distal end of the tube is fastened a silver cannula having a probe point extending some distance beyond the eye. Before charging the apparatus with blood, a clip or some form of forceps is placed on the tube, and as soon as the instrument is charged, it is allowed to stand in a small vessel of hot water, so that the blood may remain at a proper temperature until required for use. Blood is received from the vein of the donor into a clean, warm bowl, and should be defibrinated as it flows by stirring with a glass rod or a fork for a few minutes, then strained through muslin into another bowl, taking care to get rid of all air bubbles. The next step of the operation is to open a vein in the bend of the patient's elbow by transfixing it at right angles to its course with a small tenotomy knife. The apparatus containing the blood is now removed from the vessel of hot water, and a little blood permitted to escape from the eyelet hole so as to expel all air, and the cannula then pushed into the vein. When the apparatus is raised the blood will sometimes find its way into the vein by its own weight; but more frequently it is necessary to force the blood into the vein by squeezing the dilatation on the tube. The instrument possesses great advantages in simplicity, in its freedom from expense, and the readiness with which it is kept clean; besides being safer than any form of syringe, the piston of which might be out of order when required for use. It is readily seen that it is equally suitable for the making of transfusions of saline solutions, which are very often serviceable in temporarily warding off the fatal effects of the loss of large amounts of blood.—*Brit. Med. Jour.*

The Leprosy Bacillus.—Dr. Paul Guttmann, from a case of tubercular leprosy in a girl of 12, had the opportunity of examining from time to time the structure of some of the nodules after their removal. He found them in many instances so filled with bacilli that they appeared to be composed of but little else; all the cellular elements being completely packed with them. The recognition of these special bacilli is he maintains, unusually easy, even without staining. A small particle of the fresh tissue may be spread out upon the object glass in a drop of distilled water, and examined under a power of about 650 diameters, and the bacilli are then clearly seen moving actively about. In length they vary from $\frac{1}{4}$ to $\frac{3}{4}$ of the diameter of a red blood corpuscle. Most of them contain spores in varying number, and this variety suggests the possibility of the existency of several species. They are found to be susceptible to the same methods of staining as the tubercle bacillus. As regards its anatomical position, the leprous nodule begins in the corium as a collection of cells, varying very much both in form and size, and almost structureless connective tissue being very sparsely scattered between them. It is in these cells, some of which attain a size three or four times greater than that of the colorless blood corpuscles, that the bacilli accumulate. A very few can be distinguished at times in the intercellular tissue. The rête malpighii remains almost entirely uninvaded throughout, and it is only rarely that any bacilli can be detected in the papillæ, the sweet glands or ducts, or the hair follicles and epidermis. In the nodules of leprosy everywhere than in the skin, the same bacilli may be found, and they have even been detected in the blood of the general circulation, generally in the serum, but also occasionally in the white blood cells. He believes that they constitute the true cause of the disease, even though no experiments have yet been successful in communicating leprosy to the lower animals by inoculation.—*Med. Times*, February 21.

Sleeplessness.—Sleep is a perfectly natural function. It is not a negative act, but a positive process. Herein lies the difference between real sleep and the poison-induced torpor which mimics the state of physiological rest. We ought to be able to sleep at will. Napoleon and many busy men developed the power of self-induced sleep to such an extent as to be able to rest whenever and wherever they pleased, for longer or shorter periods, as the conditions

admitted. We have been led to believe that Mr. Gladstone at one time possessed this faculty. If that be so, his recent insomnia must be assumed to have been the result of such intense brain-worry as inhibited the control of the will; or there may of course, be physical causes which render the apparatus of the cerebral blood-supply less manageable by the nerve-centres. In any case, it is much to be deplored that, in the study and treatment of insomnia, the profession generally does not more clearly and constantly keep in memory that what we call sleeplessness is really wakefulness, and before it is justifiable to resort to the use of stupefying drugs the precise cause of disturbance should be clearly made out. This, of course, takes time, and involves a scientific testing of the relative excitabilities of the sense-organs central or radial and peripheral. The discovery of the cause, however, affords ample recompense for the trouble of searching for it. With the sphygmograph and few test appliances, such as Galton's whistle, an optometer, and other instruments, the recognition of the form and cause of sleeplessness can be made in a brief space, and then, and then *only* we protest, it can be scientifically—*i. e.*, physiolgically—treated.—*Lancet*, Jan. 10, 1885.

A Note on Tracheotomy.—Mr. Ashby G. Osborn, in the *Brit. Med. Jour.* of Jan. 17, 1885, report that in a recent case of tracheotomy, after inserting the tube, he was astonished to find that relief failed to ensue, and the patient, notwithstanding that artificial respiration was practised, died on the table. A necropsy showed that the tube had been passed down between the trachea and false membrane, thus pressing together the sides of the lining tube of false membrane. This source of danger, from the absence of its mention in text-books, Mr.Osborn thinks, has not often been met with. If Mr. Osborn had made it a practice, before introducing the tube, to hold the cut edges of the trachea incision apart with hooks for a few minutes, and search for false membrane at the site of and below the wound with forceps, this accident would not have happened. It seems to me that most operators insert the tube too quickly; there is no reason for hurry, and mucus and false membrane can always be removed from the trachea better before the tube is inserted than after.—*Dr. Shepherd, in the Canada Med. and Surg. Jour.*

Medical Items.

Cremation is being gradually introduced into France and will soon become recognized as a legal mode of disposing of the dead. At a recent meeting of the Council of Hygiene, Prof. Brouardel proposed to establish a crematory at Pére la Chaise, to be employed as a commencement for the incineration of bodies that have been used for anatomical purposes.

Dr. Garrett-Anderson, a sister of the wife of Prof. Fawcett, and Dr. Arabella Kenealy,a daughter of the late Dr. Kenealy, a brilliant advocate and finished scholar, are said to be the two most distinguished lady practitioners in London. Both of them enjoy large and lucrative practices and are said not to be inferior in ability to doctors of the highest standing of like age and experience.

An improved antiseptic gelatin bandage is prepared by Francis (*Boston Med. Journ.*) by incorporating one per cent. corrosive sublimate in a hot solution of gelatin in glycerin. The wound to be dressed is covered with sublimate gauze, and this is then coated with the warmed gelatin solution. Strips of gauze having been dipped in the gelatin solution are placed upon the covering, and a substantial bandage is obtained. —*Ther. Gaz.*

Two cases of epileptiform tic have recently been reported cured by nitro-glycerine.—*Med. Record.*

Drs. Seaton B. Norman, B. B. Watkins and W. Page McIntosh have passed successful examinations before the medical board of the Marine Hospital Service and are eligible for appointment as assistant surgeons in that branch of the service.

Dr. Frank Woodberry, the editor of the Phila. *Medical Times*, has been elected Professor of Materia Medica and Therapeutics in the Medico-Chirurgical College of Philadelphia.

According to the *Northwestern Lancet* a physician of St. Paul recently played a trick upon a midwife, who sent to him to borrow a pair of forceps, by giving her two left-handed blades. On returning them the next day, however, she reported that she had brought the child with them. Few men could have done more.—*Bost. Med. and Surg. Journ.*

Original Articles.

THE BACILLUS OF SYPHILIS.*

BY DR. SIGMUND LUSTGARTEN,

First Assistant to Professor Kaposi in the Dermatological Wards of the Vienna General Hospital.

Translated by J. N. BLOOM, B. A., M. D.

Since Hallier's time, a period of almost twenty-five years, the virus of syphilis has been the subject of frequent communications and of almost constant discussion. But, nevertheless, the conviction is universal that none of these researches have even partially solved the question, because of their countless contradiction, inefficient methods, and errors that are easily recognized. And further, as my effort is not a continuation of any preceding one, I will not tax your time and patience by a review of the literature of the subject, but will at once detail my own observations, referring for the literature and development of the subject to a publication of mine shortly to appear.†

My researches with syphilitic products have led to the discovery of micro-organisms which until now were unknown, which are constant in their appearance and which are thoroughly characteristic. They approach nearest in their morphological appearance and staining reaction to the bacilli of leprosy and tuberculosis, and like these are to be found in granulomata.

By means of the method about to be given they appear as straight or curved and sometimes irregularly bent rods, which are on an average from three and one-half to four and three-tenths thick. With a low power they appear uniformly smooth, presenting here and there a bulbous swelling at their extremities. With a homogeneous immersion lens ($\frac{1}{20}$ inch Reichert) their surface appears irregularly undulatory and slightly notched, yet in a manner that leaves us no doubt as to their rod nature. Within them we recognize at equal distances from one another, oval, colorless, bright spores, from two to four in every bacillus.

I never saw the bacilli lying free, but always enclosed in cells. These cells are from a trifle larger to double the size of white blood corpuscles. They are round, oval or irregularly polygonal, and sometimes show a central or eccentric oval nucleus in the shape of a light spot. The bacilli are to be found in them singly or in groups of from two to nine or more, sometimes intertwined with each other and again in irregular confusion. These cells containing bacilli occur sparingly in the midst of the infiltration; more often on the borders of the same in the apparently normal tissue immediately adjacent. I have observed them in papules embedded between the prickle cells of the rete malpighii; and also, in the initial lesion, I have found them in the lumen of a large lymphatic duct. It seems to me to be beyond doubt that they possess the power of active locomotion—migratory cells.

To obtain these results I had to employ a new method. Starting with the idea that bleaching measures would be serviceable in microscopic work as well as in the arts and in trade, I succeeded after numerous fruitless attempts in finding what I sought in permanganate of potash and sulphurous acid.

In brief the method is as follows: Sections which have been hardened in alcohol are colored in a solution of gentian violet (Ehrlich-Weigert‡) from twelve to twenty-four hours at the ordinary temperature; and then for two hours at a temperature of 104 Fahrenheit.

The section, in order to be decolorized, is first washed in absolute alcohol for several minutes, and then by means of a glass or platinum needle conveyed into a watch crystal containing about three cubic centimetres of a one and one-half per cent. aqueous solution of permanganate of potash. In this it remains about ten seconds. As a result, a brown, flocculent precipitate of the hyperoxide of manganese is formed in the fluid and also covers the sections. It is then placed in an aqueous solution of chemically pure sulphurous acid, in which it is deprived of the hyperoxide of manganese either instantaneously or in a very short time, dependent on the concentration of the acid. It now appears entirely rid of its coloring matter in some places, while

*A paper read before the Royal Imperial Society of Physicians of Vienna, March, 27, 1885.

†"Bacillus of Syphilis," *Wiener Medicinische Yahrbucher*, 1885, 1st quarter, also as a brochure, to be printed by Braumueller, *Wien.*

‡ One hundred parts of concentrated aqueous solution of aniline with eleven parts of a concentrated solution of gentian violet.

in others it is still deeply colored. It is next washed in distilled water and is again placed in the solution of the permanganate of potash, in which as in the succeeding repetitions it remains three or four seconds and from it is again conveyed to the sulphurous acid.

When it appears colorless, which as a rule occurs after this procedure had been gone through with three or four times, it is dehydrated in alcohol, rendered transparent in clove oil, and mounted in Canada balsam (xylol Canada balsam the best).

This method of decolorization not only permits the micro-organisms of syphilis to be brought to view but is a characteristic staining reaction for them. The bacilli of syphilis, tuberculosis and leprosy are distinguished from all other known bacilli in that they are not declorized by my method. The bacillus of syphilis is distinguished from that of tuberculosis and of leprosy by the fact that the syphilis bacillus is decolorized by nitric and hydrochloric acid while the bacilli of the other two are not.

My method failed in the examination of splenic fever, typhoid, equinia, endocarditis ulcerosa, croupous pneumonia, various secretions of wounds, the contents of acne and scabies pustules, and also in the examination of normal tissue. I wish also to mention that my attempt to prove the presence of micro-organisms in two chancroids were futile.

By means of the method just given I have examined sixteen cases of syphilis which I will simply enumerate without going into particulars; sections of two initial lesions, a lymphatic gland, three papules and four products of the tertiary stage, and further the secretions of three initial lesions and of the same number of moist papules.

The result was a positive one in every case. The number of bacilli found varied. In general they were not very numerous.

As regards the number, the age of infiltration and perhaps also the length of time since the infection are of importance.

Thus I found in every section of two initial lesions, and of a periosteal gumma in a new-born child, one or more groups of bacilli, and here and there quite large groups among them; whereas, in other cases, a series of sections had to be examined before the undoubted presence of bacilli could be confirmed.

According to my experience, the proof of the presence of the bacillus in syphilitic products is of equal diagnostic importance to that of the tubercle bacillus in the sputum.

Inasmuch as I have found as a constant factor in undoubted syphilitic products of various kinds a special kind of bacillus which differentiates itself in form and staining reaction from all those known up to the present time, and which, therefore, is a specific bacillus, and inasmuch as we believe ourselves justified as regards other infectious diseases in assuming the constant recurrence of peculiar micro-organisms to be the cause of disease, therefore I mention, as regards syphilis, that it is very probable that the bacilli which I have discovered are the carriers of the syphilitic virus.

In addition to this specially important result the above mentioned researches present several other theoretically and practically important facts and deductions which I will briefly mention: the occurrence of bacilli enclosed in lymphoid cells, whose power of locomotion according to my before mentioned observation is beyond dispute; further, the occurrence of bacilli in the apparently healthy tissue lying nearest the infiltration, and finally most especially their discovery in the initial lesion in a closed lymph duct support the theory that the poison of syphilis is conveyed from the point of infection first through the lymphatic system, and later through it into the blood-vessels.

The occurrence of bacilli in the rete malpighii is of great theoretical interest and accords with the clinical observation that in certain cases syphilitic infiltrations need only lose their covering of horny epidermis (moist papules) to be contagious.

As I have shown bacilli of the same nature as in primary and secondary products to exist in typical gummata, we must look upon the latter, as indeed do the greater number of syphilologists, as specific syphilitic affections.

Only a few writers have evaded the difficulty in that they consider gummata as the result of specific cachexia and not of syphilitic virus—basing their claim upon a number of negative inoculations, and pointing out that syphilitic patients in a tertiary stage as a rule produce healthy, that is, non-syphilitic children. Recall to mind how long Ricord and his followers maintained the non-infectiousness of the products of the secondary stage where the circum-

stances were so much simpler because of the much greater frequency the situation and the nature of the manifestations: further, I can not understand why, because one has some local syphilitic deposit he should not have healthy generative cells and produce healthy children. In heredity we must not forget that there are affections of the generative glands which have perhaps no subjective or clinical symptoms, yet are followed by the production of diseased generative cells, or at least of spermatic fluid containing virus. I know from a personal communication from Armauer Hansen, and I have been in a position to convince myself of it, that the testes of leprosy sufferers contain numerous bacilli in and between the seminal ducts whether symptoms of disease of the testes existed during life or not.

In the future the question as to whether a given case is syphilis, can only be *affirmatively* answered if the presence of the specific bacillus can be demonstrated.

In conclusion I venture so hope that by continuous research, particularly in the cultivation and inoculation of the bacillus which I have discovered, the etiological relation between it and syphilis will be so decidedly proven that none will deny it, and that a means will thereby be attained for successfully combating one of the saddest diseases of the human race.

The experiences of the last few years in the successful attenuation of the virus of splenic fever, and other infectious diseases warrant the hope that this expectation is not oversanguine.

VIENNA, March 23, 1885.

Messrs. Editors:—Up to the present time, Dr. Lustgarten's method of detecting the syphilis bacillus has not been made public. In a few days, however, he will deliver his address before the Vienna Society, and having been invited to assist in the translation, I am able to send it to you in advance. Doubtless it will be read with interest.

One of the most important features of his paper is his brief statement that his efforts to detect the bacillus in chancroids were futile, thus apparently verifying the dual theory.

In his various preparations, which I have had the pleasure of examining, the bacilli are clearly demonstrated, their coloring having withstood the bleaching to which the rest of the section has yielded.

From a source other than Dr. Lustgarten himself I have learned that his method and results have been well received by the few high authorities to whom he has confided them.

Very respectfully,

WALTER WYMAN, M. D.

RHINITIS SYMPATHETICA.*

BY J. N. MACKENZIE, M.D., OF BALTIMORE.

Under the above title Dr. Mackenzie proposes to group the long array of so-called reflex neuroses of the nasal passages which are at present exciting the attention of the medical world.

Whether taken singly, as in the case of asthma, cough, etc., or collectively, as in the *ensemble* of reflex acts known as "hay fever" (*coryza vasomotoria periodica*), these phenomena may, according to Dr. M., be regarded as the protean manifestations of a diseased condition of the nasal passages which is common to them all and under which they may be included as symptoms. In looking upon the subject from this standpoint, the so-called reflex nasal neuroses are the manifold semiological expression of a solitary morbid process—a peculiar hyperæsthetic or inflammatory condition localized principally in certain well-defined structures of the nasal chambers. In other words, the disease known as hay-fever, the reflex asthma, and other phenomena which proceed from nasal disease may all be classed as symptoms which, owing their origin to a common cause, form part and parcel of a single pathological process. If we inquire what condition, or conditions, is common to them all, and what morbid state is capable of producing them either singly or in combination, and how phenomena apparently so widely different in character and anatomical sphere of operation can be traced to a solitary source, we find the answer in certain more or less clearly-defined and constant changes in the nasal apparatus—from exaggerated irritability of the cavernous tissue to well-marked hypertrophic inflammation—and in a certain exalted state of the sympathetic nervous system, to which latter we instinctively turn as the organ most conspicuously concerned in the evolution of purely reflex acts. In whatever relations the local nasal disease and the condition of the sympathetic system stand to each other in the matter of cause and effect, they must both be regarded as inseparable factors in the production of the phenomena under consideration. It matters not to what hypothesis the path of speculation may lead—of this we can be

*Abstract of a paper read before the Clinical Society of Maryland April 3, 1885.

sure, that in order to the production of the characteristic symptoms of this disease, a certain excitability of the nasal passages is necessary, *plus* an exalted state of the nervous system. This irritable condition may be regarded as the incipient period of the simple inflammatory stage of rhinitis (see paper read before this Society, and published in *Phila. Med. News*, April 4, 1885.)

In assigning to the process that sets in motion this peculiar group of reflex or sympathetic acts, the term *Rhinitis Sympathetica*, as expressive of the two leading pathological factors in its etiology, Dr. Mackenzie believes that the pathway will be opened for the more rational interpretation of nasal neuroses, and the scientific generalization of their phenomena.

Dr. Mackenzie's essay is based on the study of over sixty well-marked cases of the disease and the etiology, symptoms, sequels, prognosis and treatment are fully elaborated. We give below a brief abstract of the essential points:—

General characteristics.—The attacks which characterize the affection, are paroxysmal, occasionally periodic, occur at any time, but most freqently at night, when the recumbent posture is assumed, or when lying on the most affected side. Varying in duration and severity, their onset may be sudden, or preceded by itching and stoppage of the nose, coryza, or symptoms referable to disturbance of a distant organ. Not infrequently they are terminated by sneezing and copious discharge of serum or mucus from the nostrils.

There are generally one or more symptoms which possess more prominence than the others, or a number may be associated in the same individual, notably in the case of coryza vasomotoria periodica. The association of several of the most common symptoms of this disease was formerly, and is now, known as "hay fever." The question of age, sex, race, inheritance, condition of the nasal passages as regards pathological appearances, peculiarities in structure, etc., the condition of the skull, nervous, system, etc., were next considered in detail.

Persons suffering from this disease do not necessarily belong to the so-called "nervous" variety of individual, nor do they give any appreciable past or present signs of a deranged general nervous system. No age or condition is exempt; it occurs among the highly educated and intellectual, among the pauper population, and may date its origin from shortly after birth. Sex is probably an unimportant etiological factor. The etiology may be briefly summed up as in the articles by the author in the *N. Y. Medical Record* of July 19th and October 18th, 1884.

The nasal passages present all grades of pathological change from simple irritability of the cavernous tissue to pronounced hypertrophic inflammation. Polypi, malpositions of the septum, and other anomalies of the nasal fossæ act secondarily as promotors of the irritable condition of the nasal fossæ, characteristic of the disease (see paper by the author in the Transactions of the Med. and Chir. Faculty of Maryland, 1884).

The essential distinguishing feature of the paroxysm, as far as the nasal passages are concerned, resides in the exalted state of their cavernous tissue, and especially that portion covering the posterior and inferior portions of the nasal fossæ (reflex sensitive area. *American Journal Med. Science*, July, 1883.)

Dr. Mackenzie next proceeds to discuss the question of the localization of the sensitive area from the standpoint of clinical and experimental observation and from anatomical grounds. In opposition to Prof. Hack of Freiburg, who regards the anterior end of the inferior turbinated bone as the most sensitive spot to reflex-producing impression, and who originally held that reflexes arising from stimulation of other portions of the nostril only occur secondarily, through congestion of this circumscribed locality*, Dr. Mackenzie adheres to the belief expressed in his original paper, which is furthermore strengthened by a repetition of his experiments since he came into possession of Hack's work, in which this repetition on his part is suggested.

Lack of space forbids more than the briefest abstract of the symptoms of *rhinitis sympathetica*, detailed in the paper of the author. Among those referable to the *special senses* the following may be mentioned:

Eye.—Congestion and inflammation of the conjunctiva, recurrent herpes, keratitis, phlyctenular eruptions, muscæ volitantes, and even chemosis;—spasmodic twitching of the lids, asthenopia, etc.

*Dr. Hack has recently modified this view. (*Deutsche Med. Wochenschrift*, No. 28, 1884. Reprint.)

Ear.—Tinnitus, congestion, pain, itching of external meatus, spasmodic action of tensor tympani (?), accumulation of cerumen, and clicking or snapping noises (described by Burnett), etc.

Nose.—Cough, perversion of olfactory sense, antipathy to certain odors, etc., abrogation or complete suspension of the olfactory function; peculiar constant itching at end of nose, epistaxis, redness of external nose, etc., etc.

Tongue.—Perversion of taste, tingling sensations, etc.

Mouth.—Herpetic eruptions, salivation, dental neuralgia, periodontal inflammation, etc.

Nervous System.—Hemicrania, neuralgic affections of the fifth nerves, its branches and connections, sensation of itching or formication in various parts of the body, epileptiform attacks, etc.

Muscular System.—Rheumatic pains, spasm of the lids, and facial and neck muscles, and those of the extremities.

Heart.—Cardialgia, attacks resembling angina pectoris, palpitation, etc.

Skin.—Eruptions, notably urticaria, sweats, etc.

Pharynx and Larynx.—Sudden congestion, itching and tingling sensations, spasmodic affections of the cords, (possibly aphonia) cough, etc.

Lower Respiratory Apparatus.—Asthma, bronchial irritation (congestion, perhaps inflammation). Occasional symptoms referable to *genito-urinary tract.* (Elsberg.)

Gastro-intestinal.—Irritation, dyspepsia, vomiting, etc.

Among other symptoms, were also mentioned vertigo, convulsions (in children), etc.

Complications.—Consist chiefly in certain structural changes in the organs principally concerned, in a neurasthenic condition, and in the ultimate effect of the paroxysms upon the mental faculties.

The *prognosis* will depend upon a number of different circumstances; upon the amount of structural change that has taken place in the different organs and upon the original cause of the disease and the facility of its removal. In general the prognosis can be said to be good.

The *treatment* is the same as that outlined in the author's paper on *coryza vasomotoria periodica.* (*Med. Record*, July 19th, 1884.)

In the original article a complete account of the literature of the reflex neuroses of the nasal passages is given.

A CURIOUS CASE OF CALCULUS FORMED IN THE SUB-LINGUAL GLAND, AND CHALKY DEPOSIT IN WHARTON'S DUCT.

BY EDWARD M. WISE, M. D., OF BALTIMORE.

The following case, of which the above is a brief description, I venture to think will be found of interest as being quite *rare*, if not altogether *unique*. No instance of a precisely analogous nature has ever come under my observation.

Nor is mention made of anything exactly similar in any works on pathology or surgery which I have examined. It is under these circumstances that I have found considerable difficulty in providing a reasonably descriptive title to the account.

On Feb. 4th, 1885, I was consulted by Wm. Holland, (mulatto) aged 21 years, whose occupation was that of waiter. His general health seemed somewhat impaired, and his case presented the following symptoms:

Sub-maxillary gland enlarged and slightly painful. Swelling along the entire course of Wharton's duct, as well as over the sub-lingual gland, which he informed me had been slowly increasing in size for one or two years. He said the enlargement of Wharton's duct and the sub-maxillary gland above mentioned, was more recent. The last-named structure (sub-lingual gland) was not only enlarged but indurated and very painful, while from a fistulous opening into it, there constantly oozed small quantities of pus and blood. The introduction of a probe through this orifice revealed the following condition, namely, that of the gland being impacted with a chalky deposit, which I removed on Feb. 6th, simply by cutting down on the calculus and drawing it out entire by means of a pair of small dressing forceps. The body thus taken away was about the size of a large pea, quite friable and having the general appearance of a calculus usually found in the bladder.

Immediately upon its withdrawal there followed a considerable quantity of pent-up saliva of about the consistency of albumen. Believing this mass of saliva which had hitherto been unable to find an exit fully

accounted for the swelling along the course of Wharton's duct, and that the same would now promptly subside, I gave the patient an antiseptic mouth-wash, and directed him to call again in three or four days.

Two days, however, after the removal of the calculus, he sent for me, complaining of pain in the sub-maxillary gland, and along the course of Wharton's duct, for the temporary relief of which I administered ⅛ grain of sulphate of morphia hypodermically, which had the desired effect, but on the following day the pain had so much increased that I asked Dr. J. Edwin Michael to see the case with me; and, after a careful investigation, we decided to lay open Wharton's duct, which was found filled with a chalky deposit similar to that which I had previously removed from the sub-lingual gland; and this we picked out in pieces by means of a pair of ordinary forceps. We then made a further exploration, with a small needle, from the outside, into the sub-maxillary gland, with a view to ascertaining whether that structure had undergone chalky degeneration, but no indication of the kind was discovered, and the gland soon began to decrease in size.

The patint began to improve and has since entirely recovered.

Whilst in the above account there is nothing doubtful as far as the patient's condition is concerned, the precise causes which led to it are by no means so clear, but form simply a basis for conjecture.

The following queries may suggest some such answers as to throw some light upon a case which, so far as its pathological explanation is concerned, is extremely obscure.

1. Did the opening of Wharton's duct first become obstructed through an inflammatory condition produced by some local or external cause? Under these circumstances did there follow a deposit of the salts contained in the saliva, viz., tribasic phosphate of soda, chlorides of sodium and potassium, sulphate of soda, and phosphates of lime, magnesia, and iron, combining to form this chalky calculus?

2. Did it happen that the patient managed to force with the tip of his tongue in his endeavor to remove it, a minute particle of crab-shell or other foreign substance into Wharton's duct through its opening near the frænum linguæ?

And supposing this to have been the the case, the said fragment may have acted as a nucleus around which the salts of the saliva could have encrusted themselves, gradually increasing in size so as to form a plug which in the course of time effectually closed up the opening of the duct, and produced the results narrated in the case.

199 N. Howard St.

Hospital Report.

REPORT OF THE PRESBYTERIAN EYE, EAR AND THROAT HOSPITAL FOR FEBRUARY, 1885.

BY HIRAM WOODS, M.D.

Case of Rapidly Returning Growth in the External Auditory Canal.

During the month of February there was an average daily attendance of 82 patients. There were 56 operations performed on the eye, 16 on the ear, and 6 on the throat and nose. The number of new cases entered during the month was 440.

The following case came under my care at the Hospital in January: R. L., colored, age 22, began to suffer from pains in his face during the winter of 1883–4. These pains were most severe in the region of the right ear. He was treated with quinine and other remedies with little or no benefit. During the spring and summer of 1884 he noticed a decrease in the hearing power of his right ear, and was troubled with tinnitus aurium. In August he consulted a physician who ordered him to use poultices externally, and to inject into the ear hot soap-suds several times daily. These applications were intended to "draw" an abscess, said to be behind the drum. He was also given something internally to quiet the pain. This treatment was kept up until December, 1884. At this time he consulted another physician who told him there was a polypus in his ear, removed a piece of it, and advised him to come to the Hospital. Up to December there had never been, so far as he knew, any discharge from the ear. His condition in January was as follows: general emaciation, and face betokening great pain. The right mastoid region was enlarged and painful on pressure. The pinna was pushed outwards and forwards. There was no perception of sound by either ærial or bone conduction. The external auditory canal was filled with a pearl-gray

polypoid mass. There was a scanty, thin discharge, in no sense purulent. On attempting to remove the polypus, the catgut of the snare repeatedly cut through it, and I finally removed it piece-meal with the ear forceps. There was very little hemorrhage. An examination of the ear then showed a large perforation in the drum, and, through this perforation, the mucous membrane of the tympanic cavity swollen and granular. Syringing with warm water and the use of warm alcohol twice daily were ordered, and the patient went home. In three weeks he was back again. The external canal was again filled with the pearl-gray polypus, and there was right facial paralysis. Prof. Chisolm subsequently removed the polypus at his University clinic. Within two weeks the growth was as big as ever. A piece was now sent to Prof. Councilman for microscopic examination. Shortly after this the man was discharged from the Hospital.

Prof. Councilman has given the following description of the section he examined: "I find on section that the nodule is for the most part covered with epidermis, which has made some growth downward into the tissue beneath. The tissue beneath the epidermis, and of which the bulk of the nodule is composed, is most like simple inflammatory tissue, is composed of lymphoid cells, granulation cells, and rapidly proliferating connective-tissue cells. I am inclined to think that it is nothing but a simple skin polyp, that has been much irritated and inflamed."

The chief point of interest in this case is the diagnosis. Of the nature of the growth removed by myself, and later by Prof. Chisolm, there is, I think, no question. It was, as Prof. Councilman has said, a skin polyp. Was this polyp the primary disease? This I doubt. The usual starting point of aural polypi is the mucous membrane of the drum cavity. Rarely they spring from the skin of the external canal or from the drum. Then again polypi are the result of chronic suppuration. Prof. Roosa states that when polypi start from the *external canal*, "they are the result of suppuration, that has been prolonged, or that has been augmented by the use of poultices, which have rapidly broken down the integument of the canal, and rendered it more like its neighbor, the mucous membrane of the tympanic cavity." In the case narrated there had been no suppuration at all, only a thin watery discharge for one month. On the other hand there had been intense pain for a year, the mastoid region was enlarged and tender, the pinua was pushed outwards, the drum was ruptured, the tympanic mucous membrane was swollen and granular, the conduction of sound (ærial and osseous) had been destroyed, and, later, facial paralysis had come on—probably due to involvement of the facial nerve in the Fallopian canal. All these point to chronic trouble of the middle ear. Nor do I think that this chronic trouble could have been a *mucous* polypus. The intense pain and emaciation of the patient, with the absence of previous suppuration, are against this diagnosis.

In Prof. Roosa's book are notes of a case narrated by Mr. Wilde. A child, 7 years of age suffered from an otorrhœa and a polypus. The polypus was removed and returned three days later. He repeatedly removed it, only to see it return. Shortly the child was seized with epileptic fits. A fluctuating point on the mastoid process led down to an abscess which communicated by a fistula with the auditory meatus. The abscess was opened and a fungus mass soon filled the incision. After death "there was found an osteo-sarcoma of the petrous and mastoid portions of the temporal bone."

Mr. Wilde thought "that the original disease was in the bone, and that the aural discharge and fungus were but secondary appearances."

Primary malignant growths of the middle ear are very rare. Was the case narrated one of them? There seems to me no doubt that the original trouble started somewhere in the middle ear—probably in the mastoid process—and that the skin polypus was only a secondary appearance. In the absence of any other cause the occurrence of the polypi could be charged to the injudicious use of poultices and soap-suds. Its rapid recurrence after removal, however, is striking and unusual. Looking at it in the light of Mr. Wilde's case, I am inclined to think that this recurrence strongly points to the malignancy of the original disease.

Lightning has killed 4,609 persons in France since 1835. An equal number have been seriously though not fatally wounded, and five times as many struck.

Society Reports.

PROCEEDINGS OF THE MEDICAL SOCIETY, DISTRICT OF COLUMBIA.

STATED MEETING HELD FEBRUARY 18TH, 1885.

The Society met with Vice-President, DR. W. H. TAYLOR, in the chair, DR. MCARDLE, Secretary.

Dr. H. D. Fry reported a case of

PUERPERAL SEPTICÆMIA.

Was called to see Mrs. —, white, primipara, æt. 17 years, on Thursday, Feb. 5th. Learned that she had had fever for five days, accompanied by constant vomiting and purging. At that hour (11 A. M.) her pulse was 160 and temp. 103.8. Fundus uteri about two inches above symphysis. Some tenderness in the left iliac fossa. Finger passed into the uterus through a lacerated and dilated os; when withdrawn it had the odor of decomposition. No lochia had escaped for several days. Gave morph. sulph., gr. ¼, by hypodermic injection. Ordered quin. sulph., gr. xv, at once and directed poultices to abdomen.

I obtained the following facts from the physician in attendance at the confinement, whom the family had become dissatisfied with and unjustly discharged: False labor pains had commenced Monday, Jan. 16th, and had kept up until Friday, the 30th, when, by the advice of a consulting physician, he ruptured the membranes. The os at the time was but little dilated. The discharge of amniotic fluid was followed by regular labor and the birth of a premature child. Fever commenced Sunday (Feb. 1) and on Wednesday her temperature was 104.5. He gave that day an intra-uterine injection and two doses of quinia sulph., each grs. xx. Vaginal injections had been commenced earlier.

The next day (Thursday) Dr. Fry found her as stated above. At 4 P. M. of the same day she was found relieved of the vomiting; has had no diarrhœa and had slept most of the time since his morning visit. Pulse 160, temp. 103.2. An intra-uterine injection of a hot two per cent. solution of carbolic acid was given. Large quantities of mucus and bloody shreds were brought away in the returning fluid. The canula had to be removed twice to cleanse it during the injection.

The quinine was directed to be repeated at 6 P. M. Milk punch every two hours. Nine P. M., pulse 140, temp. 104.8. Intra-uterine injections repeated; water returned clearer. Morph. sulph., gr. ¼, hypodermatically. Cervix red and inflamed. Vaginal injections of sulphate of copper solution ordered every three hours.

Feb. 6th, 9.30 A. M. Had slept well the early part of the night. Pulse 160, temp. 104.2. Intra-uterine injection brought away a considerable quantity of shreddy tissue.

12.45 P. M.—Pulse 134, temp. 103. Fluid of intra-uterine injection returned clear. Pure carbolic acid was applied to the ragged edges of the lacerated cervix. Vaginal injections continued every three hours. One ounce of whiskey ordered every two hours. Hypodermic injection of gr. ¼ morphia sulphate.

7.30 P. M.—Pulse 130, temp. 103. Uterine cavity washed out and fluid clear.

Feb. 7th.—With the assistance of Dr. H. L. E. Johnson intra-uterine injections were given at 9.30 A. M., 12.45, 3.30 and 10.30 P. M.

The pulse and temperature at each of these hours were:

Pulse.	Temperature.
160	103.8
160	105.
180	106.4
154	101.8

Mucous membrane of vagina became dry and covered in patches with diphtheritic deposit.

Feb. 8th.—Failing steadily. Vagina covered throughout with the pseudo membranous deposit. Intra-uterine injections had to be discontinued. Vagina was washed out with carbolic acid solution (1 to 40) every two hours. Quinine and whiskey, also hypodermic injections of morphia when necessary, had been continued. Became delirious, and at 11.30 P. M., her temperature was 107.2. Died at 9 A. M., Feb. 9th.

DISCUSSION.

Dr. Smith thought that no one present would at this moment advise delivery when the cervix was rigid and dilated about an inch. But in many such cases the doctor is in a tight place. The patient has been in labor for days and the family is importunate. The accoucheur loses his head and acts sometimes against his better judgment.

But was the sequence of events in this case due to the rupture of the membrane? In his practice when the perineum or cervix was ruptured the patients do not suffer from puerperal disease. On the contrary, puerperal fever and septicæmia occur more frequently after easy labors. He recalled a case where there was no trouble until the third day, when abdominal symptoms set in and the patient died of peritonitis. He thought the death in this case was due to bad nursing. A few years ago he reported two cases of puerperal septicæmia occurring at the same time, both of which followed exceptionally easy labors.

Dr. Hamilton said in these cases there is frequently a disposition to attribute the subsequent peritonitis to some trifling circumstance. Some years ago he delivered a woman with forceps. About fifteen months later he delivered her again without being compelled to use instruments. A week later she caught cold or metro-peritonitis supervened and she died. If death had occurred after the first delivery it would have been attributed to the use of forceps. But he believed forceps were not often the cause of these diseases. They are more often due to retained secundines. He saw in this city a woman die from blood poison three months after delivery, because the uterus had not been entirely emptied. In that case no laceration could be discovered. He thought we went too far in giving a definite cause in all these cases.

Dr. Fry did not exactly blame the first physician who first attended the case reported by him. Besides he had availed himself of a consultation. But he did think some other method of procedure would have been better. Chloral and morphia could have been used. If the pains were false morphia would properly have stopped them; if true, it would have made them more efficient. As to nursing, he did not think she got the best attention, but she got the best her husband knew how to give. He thought septicæmia and kindred diseases more frequently follow difficult labors. Puerperal fever is generally referred to retained secundines. He thought we did not refer enough to traumatism. The woman's uterus is now constantly douched. When the cause may be some traumatism this side of the uterus.

On motion the discussion was closed and the society adjourned.

CLINICAL SOCIETY OF MARYLAND

STATED MEETING HELD MARCH 20, 1885.

(*Specially Reported for the Maryland Medical Journal*)

The Society was called to order by the President, Dr. B. B. Browne, at 8.40 P. M., Dr. Jos. T. Smith, Secretary.

Dr. W. F. Coleman read the first paper upon

THE OPHTHALMOSCOPE IN DISEASES OF THE BRAIN.

(See Md. Med. Journ., March 28th).

Dr. H. Woods thought the giddiness and vomiting which preceded the neuritis a point to be noted. He noted the following: A child of five years fell on the back of its head and was unconscious for several hours. At the end of a week complained of failing sight; examination showed white atrophy in each disk; iron and strychnia were given. From her recovery of consciousness until sight failed she suffered from giddiness. In a second case, a child, seven years old, fell in walking through the car of a train, while travelling. Giddiness and vomiting came on; sight failed; examination afterwards showed advanced neuritis. Iod. potass. and strychnia were given. The third case was that of a lady of fifteen. She was taken with nausea and headache, and made a recovery under hydrg. bichlor.

Dr. A. Friedenwald thought the subject a very interesting one, but was convinced that the value of the ophthalmoscope in the localization and determination of the character of brain diseases has been much overrated. It is interesting to observe that a small tumor will cause a choked disk, while a much larger extravasation of blood will give no such result. It is due no doubt to the fact that the tumor causes congestion and effusion into the ventricles and thus the eye is indirectly affected. He then related the following: A young man came into the hospital with convulsions, he was an epileptic, blindness came on and upon examination syphilis was thought to be the cause and he was put upon mercury and iod. potass.; convulsions were relieved and sight recovered to a great degree. In a second case a young girl suddenly lost sight in one eye; found a choked disk and retinal infiltration; she had vertigo and slight brain symptoms. On iod. potass. she recovered almost en-

tirely; it is much to be doubted if a brain tumor existed in this case. A choked disk does not mean a tumor of the brain. Even a skillful oculist cannot always say whether or not there is brain disease from the appearances of the eye.

Dr. J. G. Wiltshire had seen a case of choked disk in a patient with meningitis; pupils were dilated. At this time no improvement under sub. mur. hydrg. Pressure may be caused by an effusion of serum between layers of the optic nerves.

Dr. E. Meierhof related the following: A man, aged 37, had suffered from pain in his head for several years; had recently lost vision in one eye; his physician thought his trouble due to syphilis, but could find no evidence of that affection. Examination showed choroid retinitis with atrophy. The appearance of the patches would point to syphilis as the cause of the disease. The energetic employment of anti-syphilitic treatment was rewarded by the recovery of the patient.

Dr. A. B. Arnold thought the paper one of value, and that the ophthalmoscope was a great aid in making a diagnosis in many cases. In chronic brain troubles the difficulty of making a diagnosis is great, and the ophthalmoscope in such cases may render valuable service. Instead of being an early symptom, the neuritis shows itself most too late to render us as efficient aid as it otherwise might. Nearly all brain tumors will give rise to the choked disk. He related the following case: A girl, aged twelve years, fifteen months ago had a tottering gait; was blind when seen; had headache and would vomit at times; he thought she might have brain trouble and had the eyes examined and neuritis showed itself in both eyes; from the symptoms collectively he located the tumor about the superior peduncles of cerebellum; without the ophthalmoscope the disease would have been somewhat in doubt.

Dr. W. F. Coleman thought optic neuritis a valuable aid in determining the existence of brain disease, but does not think choked disks of necessity signify a tumor of the brain. Glioma is a most frequent source of neuritis.

Dr. R. Winslow read a paper entitled

MEASURES DEVISED FOR THE RELIEF OF PYLORIC STENOSIS.

Until within the past six years, with the diagnosis "stenosis of pylorus" the fate of the patient was irrevocably sealed. The cause of the disease in the vast majority of cases is carcinoma. In most cases a tumor can be discerned in right hypochondriac or epigastric region, though not always. Uncontrollable vomiting without bile, gastric distress, stools more and more scant, and at times ectasis of stomach are the prominent symptoms. Long existing indigestion, habitual pain and vomiting eventually coming on, tumor in pyloric region seemingly connected with stomach, and the possibility of dilating the organ all point to stenosis of the pylorus and make the diagnosis almost certain; eminent men have, however, made mistakes. The gastroscope has been advised, but it is an expensive instrument. No hope is offered by internal medicine. Merrem proved seventy years ago that dogs would live with portions of the stomach excised. Pylorectomy is of gradual growth, animals being first experimented with. Six operations have been performed for relief of stenosis of pylorus: 1. Pylorectomy. 2. Gastro-enterostomy. 3. Gastrectomy. 4. Gastrostomy. 5. Duodenostomy. 6. Digital divulsion of the pylorus. Up to the present time the first has been performed over sixty times, resulting in sixteen recoveries or 23⅔ per cent.; they have been done in all parts of the globe; the time required for the operation varied from one to five hours; the amount of tissue removed varied, in some cases nearly five inches having been removed from greater curvature.

Adhesions to pancreas, extensive adhesions to transverse colon and diffuse carcinamatous infiltration render the operation dangerous, the last unjustifiable. The operation is indicated by, 1. Carcinoma; 2. Ulcer of the stomach; 3. Stenosis from swallowing a caustic liquid. The majority of operations have been performed for carcinoma. Collapse is assigned as the cause of death in twenty-seven cases; three died of inanition and ten of peritonitis; fifty per cent. succeeded to collapse in less than twenty-six hours. Gastro-enterostomy has been performed thirteen times, first by Dr. Woelfler in September, 1881; it is easier to perform than pylorectomy. It is an operation that does not aim to produce a radical cure; but only for the temporary relief of vomiting and distress; of the thirteen cases, four recovered from operation. The speaker

thought the method particularly applicable to ulcer of stomach. Statistics show thirty per cent. of recoveries, which might have been increased had the operation been performed sooner.

Duodenostomy or establishment of a duodenal fistula has been performed three times, all of which cases were fatal, probably because operation had been too long delayed.

Digital divulsion of pylorus was devised by Prof. Loreta, of Bologna. It has been performed six times, with three recoveries, and are at last accounts doing well, though this does not profess to be all the operations that have been performed, but all that could be found at time of writing. The results of the operation are not very gratifying. Casati says digital divulsion presents three great advantages over resection: 1. Its execution is easier. 2. It is less dangerous. 3. The conservation of a portion of the stomach. The average duration of operation was 32¾ minutes.

Conclusions.—As in croup, stenosis of the air passages is the indication for tracheotomy, so stenosis of the pylorus is the indication for any operation upon this portion of the stomach in cancerous affections. If the patient simply suffers pain or distress, let him have opium freely enough to overcome it. There is no probability that an operation would effect a permanent cure, and mortality is too great to perform it for a slight temporary benefit. Let such patients have anodynes. When stenosis is present something must be done or the patient will die of starvation. If the patient is young, with a considerable degree of strength, and the tumor circumscribed and not adherent to the surrounding organs, a resection may be performed, with, however, only a prospect of saving one-half of those submitted to it. When, however, the patient is feeble or aged, and there are adhesions to the pancreas or infiltration of the neighboring glands, resection ought not to be performed. In such cases gastro-enterostomy would effect all that could be expected from resection, with less immediate danger, and would be much more satisfactory than duodenostomy or gastrostomy with a tube pushed through the stenosed orifice. In fact I do not think I would be far wrong in assuming that bet ter results would follow gastro-enterostomy in all cases, though I hold it to be justifiable to perform pylorectomy in those very exceptional cases in which there are no adhesions or extended glandular involvement, and the strength of the patient is still fairly good.

For stenosis due to ulcer or to corrosive liquids which have been swallowed, whilst resection if successful is probably permanent in its effects, I think the results obtained by Loreta from digital divulsion demand our most earnest attention. In my opinion divulsion should be substituted for resection in all cases of simple cicatricial stenosis which are amenable to this treatment. I can readily imagine a condition in which the development of cicatricial tissue has gone to such an extent that digital divulsion would be impossible; in such cases pylorectomy remains, or what would be still better in some cases, gastro-enterostomy.

Summary.—1. In cancer of stomach, not producing stenosis, give anodynes in quantities sufficient to relieve distress, and do not operate.

2. Pylorectomy for carcinoma is followed by seventy-six per cent. mortality; hence it should only be very exceptionally performed—in those cases where, with marked stenosis, the pylorus is not adherent to the neighboring organs, and the patient is young and fairly strong.

3. In other cases of carcinomatous stenosis, as only very temporary benefit can be obtained, perform gastro-enterostomy.

4. In cicatricial stenosis perform digital divulsion, but if this is impossible owing to great thickening of the walls, resection in those who are well nourished and gastro-enterostomy in the debilitated will be followed by good results.

5. In the opinion of the writer hemorrhage or perforation from ulcer or other cause than stenosis does not present indications for pylorectomy.

6. Duodenostomy, gastrostomy for the passage of a tube and complete gastrectomy should all be replaced by gastro-enterostomy.

Dr. W. B. Platt exhibited specimen of

GREAT HYPERTROPHY OF THE CLITORIS; ALSO PHOTOGRAPH OF PATIENT BEFORE OPERATION.

The growth was removed at Bayview Hospital by Dr. Platt, March 16th, from a young mulatto, aged twenty-five. It was said to be of three years' growth only. The patient was a syphilitic and had condylo-

mata about anus. Tumor measured 5¾ inches long and 8 inches in circumference, hanging over entrance to vagina as far as anus, causing pain in back and difficult urination. Growth removed by thin cuts, and ecraseur for the rest of tumor. Rapid recovery without a bad symptoms.

Dr. I. E. Atkinson exhibited two casts as showing the anomalies of the female genital organs. Both were from colored women, who were prostitutes, and suffered from syphilis. In one case both labiæ were involved in the enlargement; in the other the hob-nailed appearance of the parts was seen, though not, of course, perfectly seen in the casts. The women were cachectic and the new growth was no doubt due to chronic inflammation. These troubles may be produced by many different causes; anything that will cause long continued inflammation with infiltration of the lymphatics.

Dr. W. T. Councilman exhibited a

SPECIMEN SHOWING CONGENITAL SMALLNESS OF THE RIGHT KIDNEY WITH ENORMOUS COMPENSATING HYPERTROPHY OF THE LEFT KIDNEY.

The case came from a man of forty, who died at Bayview of typhoid fever. The right kidney, which lay much lower down than is normally the case, was 1¼ inches long and ¾ of an inch broad; it weighed only a few grammes. There was a patent ureter leading to the bladder and the kidney had evidently functioned. The renal artery on the left side was twice the normal size, and on the right was wanting, the right kidney receiving its blood supply from a branch given off from the supra-renal artery. Both of the supra-renal capsules were of ordinary size and consistency. The histological examination gave interesting results. The right kidney was a perfect organ in miniature, having all of the histological elements of the normal kidney. The glomeruli, the collecting and convoluted tubules, were all present and were of normal size and texture. The pelvis was divided up into the calices into which the pyramids emptied and from the pelvis a very small open ureter led into the bladder. The large size of the left kidney was due not to a simple increase in size of the histological elements but to an increase in the amount of normal kidney substance. In such a case as this we must have either an insufficient amount of embryonic material deposited for the development of the kidney, or there is a sufficient amount of embryonic material, but it does not develop owing to insufficient vascular supply. Some cases may also arise when the proper development of the kidney may be due to some accident of embryonic life. A great deal of work has been done in order to determine the exact nature of the kidney hypertrophy.

Rosenstein investigated the question experimentally by extirpating one kidney in a rabbit and studying the compensating hypertrophy caused in the other. He found no increase in the size or number of the histological elements, but thinks the increased size of the organ to be due merely to the increased contents in blood, lymph, and urine. Perls examined nine cases of defect in one kidney with compensating hypertrophy; eight of these cases were due to a hydronephrosis on one side and due to granular contraction limited to one kidney. He found the number of convoluted tubules in a given area of the cortex to be increased and the epithelium was larger. Gudden extirpated one kidney and testicle in new-born rabbits and found chiefly increase in the size of the malpighian corpuscles on the hypertrophied side.

Benner has examined three cases of hypertrophy in man and thinks it a true hypertrophy due to an increase in size of the histological elements and not a hyperplasia in the sense of Virchow.

It is more rare in these cases for one kidney to be absent entirely than to be rudimentarily present. In the forty-eight cases collected by Benner, the kidney was absent entirely in forty-four cases. It would seem also to be more often found in males than females. From Brenner's table we have males twenty-six, females fifteen; in others sex not given. Clinically such cases have some importance. A case was mentioned where a prominent gynecologist found on opening the abdominal cavity a large kidney which he had mistaken for an ovarian tumor. The kidney was removed and the woman died ten days after from suppression of urine. At the autopsy it was found that the removed kidney was the only one which the patient had. Some of the cases in which but one kidney is present, have further malformations of the

genito-urinary tract. Cases have been reported where the seminal vesicle on the same side was wanting, and Eppinger reports a case combined with with hermaphrodism.

Dr. I. E. Atkinson spoke of a similar case, which came under his observation, in which the left kidney was exceedingly minute located over the promitory of the sacrum about in the median line. In reply to a question from Dr. Browne, he said it occurred in a man.

Dr. J. H. Branham exhibited

SPECIMENS OF TWO TESTICLES FROM A PATIENT AGED 40.

The patient had had a sore on his penis and there was a suspicion of syphilis. The diagnosis was that of tuberculosis with a probability of syphilis. Also exhibited specimen of an eye from a boy six years old. Tumor began last September; was opened; still continued to grow, and was a second time opened as it was thought to contain matter of some kind. The tumor shows behind the enlarged trunk of the optic nerve; the microscope shows the trouble to be glioma.

FOREIGN BODY IN THE EYE.

Dr. A. Friedenwald related the following: A girl, five years old, fell upon a pencil; it entered the corner ot the left eye, penetrated the skin, and entered the orbit but without injuring the bones or the eyeball itself. Upon examination, much tumefaction was found, and when the lid was drawn up pus came from wound. A poultice was ordered, and upon a second examination something black was seen; chloroform was given, the forceps introduced and piece of the pencil was withdrawn. Improvement commenced on removal of foreign body.

BEZOATE OF AMMONIA is relied upon by some in enlargements and irritations of the prostate gland, and in hypertrophy of the bladder with alkaline urine. It distinctly renders the urine acid when phosphatic deposits are present. It combines also with the glycocin or sugar of gelatine in the bile, and has some obscure curative relation to some bilious troubles. In jaundice there is a deficiency of glycocin. The dose is fifteen to twenty grains.—*Med. Record.*

Editorial.

VIVISECTION IN GREAT BRITAIN—The English law, as is doubtless known to most of our readers, almost debars experimental physiologists in that country from the important aid afforded by vivisection. According to the *London Times* (quoted in the *Ther. Gazette*) it appears that fifty-two persons held licenses at some time during the year 1883 to perform experiments. The total number of experiments of all kinds was 589. In fifty-five of these the use of anæsthetics, otherwise imposed on all, was dispensed with by special certificates, and in 122 the certificates allowed the operators to dispense with the obligation otherwise imposed to kill the animals before their recovery from the anæsthetics. Cats and dogs, about which the sympathies of the Baltimore spinsters are so deeply aroused, seem to have escaped almost entirely, only four or five having suffered. Of the entire number in the 290, the animals were entirely insensible during experimentation and their sufferings quite unappreciable. In the fifty-five the operations consisted in simple inoculation or hypodermic injection with morbid matter whose effects it was desired to discover, and the pain was not more than that of vaccination. Of the 122, 114 were principally inoculations designed to elucidate the nature of tubercular affections; trifling pain was inflicted in fourteen or fifteen instances; in eight cases the pain may have amounted to about that of the healing of a surgical wound. The inspector concludes the report, which was the subject of comment by the *Times*, by saying that "the amount of direct or indirect suffering from the performance of physiological experiments during the past year was wholly insignificant and limited to about fourteen or fifteen animals.

THERAPEUTIC GAZETTE.—This journal, located in Detroit and published by Geo. S. Davis, of that city, has, with the first number of the year 1885, been placed under the editorial management of Drs. Horatio C. Wood and Robert Meade Smith, of Philadelphia, both well known in connection with therapeutical and pharmacological investigations. The first two numbers, which have reached us, give evidence of very decided improvement in the quality of

the contents. Hitherto this journal has been conducted very much on the *Medical Brief* order. The new editors announce their intention to make the *Gazette* "a purely scientific journal, discussing without fear or favor all scientific questions within its scope, but avoiding with absolute silence all ethical questions whatever." With reference to the tendency to separate theoretical from practical therapeutics, observable in Europe, they declare that however attached to the modern scientific school of pharmacology they declare their belief "that knowledge is of value to the physician, as a physician, only in so far as it enables him to relieve the sick, and that the attempt to isolate the scientific medical savant from the practical doctor is fraught with ill." We wish and predict for the new management the largest success.

MEASURES TO AVERT THE ORIGIN AND SPREAD OF PUERPERAL FEVER.—The very marked diminution of puerperal mortality, as shown by statistics from the maternity institutions of this country and Europe, has followed the introduction of antiseptic principles into obstetric practice in these institutions. In order to show the influence of the antiseptic procedure outside of these institutions, Battlehner, in a paper read before the German Gynecological Society, having the foregoing title (*Amer. Jl. of Obstet. for April*, pp. 433-4), presents the following brief statements relative to the Grand Duchy of Baden. In the year 1875, 530 puerpera died. After the introduction of antisepsis, the mortality sank, in 1880, to 450, in 1881 to 380, in 1882 to 225; in an average number of 56,000 parturitions from 0.95 per cent. to 0.4 per cent., or more than half. Whilst these figures furnish proof of an essential progress, Battlehner argues that a further reduction of mortality must be aimed at, and he indicates the means by which this reduction can be accomplished. According to last year's statistics from Baden, he found that physicians were present at about six per cent. of the labors, whilst ninety-four per cent. were attended by midwives. This fact demonstrates the importance of improving the present status of midwives, so as to enable them to satisfy the higher requirements made of them today, especially the rules of antisepsis. In order to attain this end, Battlehner recommends the following measures: "1. Care in the selection of pupils. All unsuitable elements must be rejected by the local medical officials, and later by the instructors. 2. Improved instruction. B. holds a period of instruction of at least six months, uniformly throughout the entire German empire, to be absolutely necessary in order to impress the laws of antisepsis so firmly into the midwives that they will carry them out in practice, and not omit them altogether for one or other reason. 3. Stricter supervision. For this purpose he recommends annual district examinations by the instructors and local medical officials, together with revision of their day-books; moreover, for those midwives who show defective knowledge, a supplementary instruction for three or four weeks. In case they should refuse the latter, the license to practice should be withdrawn from them. Others have proposed that the school teacher of the locality should give each midwive once a year a brief course of instruction in the ordinary branches to refresh the memory." Battlehner also advices that midwives should be given explicit and clear directions about the antiseptic procedure, and should be furnished with disinfectants gratuitously.

In this country, where every woman who desires can practice as a midwife without previous experience or training, the suggestions offered by Battlehner may seem to be utterly useless, but a few points in this connection may be worthy of consideration. The author has shown a marked diminution of puerperal disease since the introduction of antisepsis in obstetrics, and he indicates how a further diminution of mortality may be reached by instructing midwives, who do the largest amount of obstetric work, in the principles of antiseptic practice. It occurs to us that much could be done among the ignorant classes of midwives in this country by a system of missionary work, which would have for its object instruction in cleanliness, and in the use of antiseptics in their work. Many of these women may be reached through their relations with physicians, and others might be brought under some educational influence, brought to bear by direct or indirect methods. When it is remembered that the majority of women in our large cities are attended only by the midwives, there seems to be an ur

gent need for some better preparation and training of these women for the important duties they attempt to perform. Physicians coming in relation with these women should attempt to inform them in reference to the origin and spread of puerperal disease, and the methods of enforcing cleanliness and disinfection during their attendance upon lying-in patients. In this special line there seems to be a need for the widest display of charity and missionary zeal. If some of the younger members of the profession, who are guided by humane and charitable sentiments, would inaugurate a movement having for its object the instruction and regeneration of midwives in the essential principles of their work we feel assured that beneficient results would follow their efforts. The midwife in this country is a most neglected, slighted and much abused person. Very few people seem to feel any interest in her welfare or in her mission. She is allowed to perform a responsible duty, and in her ignorance and incapacity to jeopardize many lives among a class of people who oftentimes can be poorly spared to society. Surely if there is anything which needs reforming it is the present status of the midwife. We would gladly welcome a reformation in the interest of the ignorant and helpless poor women of our large cities.

The Bacillus of Syphilis.—The active and energetic efforts which have been made during recent years to discover the micro-organisms peculiar to certain maladies have resulted in the detection of bacilli which have a constant relation to certain of the infectious diseases, notably leprosy, cholera and tuberculosis. Whilst numerous attempts have been made to discover the bacillus of syphilis this micro-organism has remained unknown until quite recently. In another column we are enabled, through the courtesy of Dr. Walter Wymen, of this city, now residing in Vienna, to present a paper, recently read before the Royal Imperial Society of Physicians of Vienna by Dr. Sigmund Lustgarten, in which the discovery of the bacillus of syphilis is announced, and the methods given by which this discovery is made certain. Dr. Lustgarten's researches are of the greatest interest and value, and go far towards clearing up the points of doubt which have shrouded the virus of this specific malady. The morphological appearance and constant presence of these micro-organisms in different syphilitic products have been carefully confirmed by methods of staining which can leave little doubt as to the accuracy of the discovery. The method of decolorization employed, Dr. Lustgarten claims, not only permits the micro-organisms of syphilis to be brought out, but is a characteristic reaction of them.

The fact that attempts to prove the presence of micro-organisms in two chancroids were futile is an apparent verification of the dual theory. The influence of this discovery on the diagnosis and treatment of syphilis is of far-reaching importance. Dr. Lustgarten asserts, as the result of his experience, that the proof of the presence of the bacillus in syphilitic products is of equal diagnostic importance to that of the tubercle bacillus in sputum. Inasmuch as he has found as a constant factor in undoubted syphilitic products of various kinds a special kind of bacillus which differentiates itself in form and staining reaction from all those known up to the present time, Dr. Lustgarten believes that he is justified in assuming that the bacilli he has discovered are the carriers of the syphilitic virus.

Another important deduction is made from these researches which supports the theory that the poison of syphilis is conveyed from the point of infection first through the lymphatic system, and later through it into the blood-vessels.

Dr. Lustgarten expresses the hope, which will receive universal affirmation, that by continuous research, particularly in the cultivation and inoculation of this bacillus, the etiological relation between it and syphilis will be so decidedly proven that none will deny it, and that a means will thereby be attained for successfully combatting one of the saddest diseases of the human race. The experiences in the successful attenuation of the virus of splenic fever, and other infectious diseases, he thinks, warrant the hope that this expectation is not over sanguine.

Dr. T. H. Wingfield died at his residence at Towsontown, Md., on March 30th, in the 59th year of his age. During the war he served on the medical staff of Gen. R. E. Lee.

Miscellany.

The Treatment of Asthma.—According to Dr. Rodet, the best means of overcoming a paroxysm of asthma consists in subcutaneous injections of morphia and inhalations of iodide of ethyl. Twelve drops of the latter, poured on a handkerchief and inhaled, procure almost immediate relief. The different papers and cigarettes which have been recommended are worthy of a trial, a change of air and occupation is often essential. In catarrhal asthma, the treatment must be directed against the bronchitis and laryngitis, which are often benefited by a stay in a warm climate. According to M. Hardy, very good results are sometimes obtained by means of a blister applied to the thighs or arm. In nervous asthma, bromide and iodide of potassium are the most useful remedies, especially the latter. Gymnastics and baths of compressed air can also be recommended.—*Journal de Médecine de Paris*, No. 25, 1884.

Chloral Hydrate for Chordee.—In the *Med. Age*, Dr. Morris C. L. Kitchen says that for two years he has been using chloral hydrate, gr. x., potas. bromid., gr. v–x to aq. dist. ℥j as an injection for chordee, and has *never* known it to fail of affording perfect relief. He usually adds morph. sulph., gr. ij to the ℥j.

He does not think that chloral hydrate, or this mixture, is indicated in all stages of the disease; but when chordee comes on, he can confidently recommend the use of it, and usually no other injection is needed afterwards.

Monsel's Iron in Diarrhœa.—Dr. E. T. Williams says in the *Boston Med. and Surg. Journ.*: "Ever since I began practice in in 1868 I have been looking for a really satisfactory astringent in chronic catarrh of bowels. There is, as every one knows, a class of cases where the ordinary vegetable astringents fail to act, or at least act too feebly to do real good. The intestinal lining is in an ulcerous, or quasi-ulcerous, condition, and requires the potent action of a mineral astringent to treat it, as in cases of external ulcer. The acetate of lead is one of the best remedies in these cases, but cannot be safely given for any great length of time. Oxide of zinc in pill form is safe and efficient, but with children, who must take it in powder, often vomits and gripes. Sulphate of copper and nitrate of silver are still harsher, and for children quite out of the question. Subnitrate of bismuth is worse.

"I began trying, in 1876, at the Seashore Home, iron alum (the officinal sulphate of iron and ammonia). I found it better than anything I had previously tried, and have used it freely ever since. It is not quite so well borne by the stomach as lead and bismuth, but far better than zinc or copper. The dose for a child is from one to three grains; for adults, from three to ten. At the Seashore Home we make powders containing one grain of the salt to a twelfth of a grain of opium, giving one or more for a dose according to the age of the child. For adults the pill form is of course preferable. I have had the best results from its use.

"Last summer I began using Monsel's salt in its place, both in public and private practice. This I did from my experience of its great efficiency as a styptic, and a presumtion that it might do equally well in diarrhœa, and have found it even better than iron alum. I have tried it only in the dry form, manufactured by Squibb under the name of pulvis ferri subsulphatis. In this State it is not officinal, though it is precisely the same as the officinal liquid ferri subsulphatis evaporated to dryness. It may be given in the same doses and in the same way as iron alum."

A New Test for Bile Acids in the Urine.—Dr. Oliver, of Harrogate, has, during the past week, been demonstrating in several of the London hospitals what he believes to be a new test for the detection in the urine of the derivatives of the bile salts. It is in the form of a test solution, and also in that of test paper. The reaction of the test is founded on the physiological fact that when the bile mingles with acid solution of peptones in the duodenum, the proteids are instantly and completely precipitated. The test solution is an acidulous antiseptic solution of peptone, and does not present to the urine a constituent extraneous to the organism. When brought into contact with a urine containing a bile-salt derivative, a precipitate resembling that of albumen when thrown down by nitric acid at once appears. By using a standard of opacity to represent the very delicate re-

action induced in normal urine, Dr. Oliver showed how the quantity of the bile derivatives, as they appear in the marked deviations encountered in disease, can be readily guaged. He has, we learn, found bile acids plentifully present not only in the urine of jaundice and of other hepatic affections, but in that of several cases of anæmia (simple or idiopathic, leucocythæmic or malarial), and of other morbid conditions; and his observations generally appear to be of some clinical interest. We understand that Dr. Oliver is preparing for early publication the data he has collected.—*Lancet.*

Qualifications for Practice—The conviction of Dr. Buchanan on a charge of conspiracy to issue bogus diplomas, suggests the inquiry as to whether it is more reprehensible to issue bogus diplomas to men who are not qualified to practice medicine than it is to issue genuine diplomas to men equally unqualified. There is reason to believe that a large percentage of the doctors sent out by colleges are no better qualified to practice medicine than Buchanan's bogus fellows. Buchanan, doubtless, deserves all the punishment he receives, if not more; but one cannot help thinking that there are a great many gold-rimmed professors in different parts of the country who are just as bad.—*The Philadelphia Evening Item*, March 12, 1885.—*Med. Record.*

Use of Drugs in Nursing Women.—Fehling, of Stuttgart, read a paper on this subject: The question to what extent drugs given to nursing women affect the nursling, is of decided interest to the forensic physitian. F. even knows of a case in which legal investigation was set on foot because an infant had died after its nursing mother had been given an injection of morphine. As the statements in literature on this question are sparse and uncertain, F. has endeavored to furnish information by experimentation. The following are briefly his results:

When the nursing woman was given from one to two grams of salicylate of sodium the drug could almost invariably be demonstrated in the child's urine. This transferrence occurred most rapidly when the child was applied to the breast about one or two hours after the exhibition of the drug. Experiments with iodide of potassium also gave positive results.

Iodoform enters the milk and the child even when given in minute quantities. Almost without exception iodine could be demonstrated in the urine of nurslings whose mothers had had their vulvæ dusted with iodoform. For this reason F. advises caution in the use of iodoform dressings in nursing women. Experiments with corrosive sublimate on animals yielded partly negative results. Only occasionally was it possible to demonstrate mercury qualitatively but not quantitatively. Different acids such as hydrochloric, citric and acetic, when given to the mothers had no appreciable effect upon the children. The same is true of narcotics. Especially after even medicine and strong doses of morphine, opium and chloral hydrate could a deleterious effect never be shown. Only occasionally long-continued sleep followed.

In the case of atropine pupillary dilatation ensued after greater than maximal doses. Otherwise no injurious effect could be observed.

F. is of opinion that these experiments prove that nursing women may be given drugs even in large doses without fear of injurious effects on the infant. The only cautions being against cumulative effects. He added the remark that the fear of allowing feverish puerperæ to nurse is likewise unfounded. The assertion made by many that psychical excitement of the mother acts on the child through the milk he states also to be nufounded.—*Trans. of German Gynecolog. Soc., Amer. Jour. of Obstetrics*, March.

Treatment of Acute Peritonitis by Abdominal Section.—The extreme fatality of acute diffused peritonitis—especially of that form due to perforation—and the acknowledged futility of the modes of treat ment that are at present employed, give some support to the proposal that acute peritoneal inflammations should be treated by the same methods that are successfully applied to other acute inflammations, namely, be free incision and drainage. This common and general surgical procedure has been already applied for the relief of inflammations of certain of the serous membranes. It was at first adopted in connection with the smaller serous cavities as those of the joints. It has been gradually and with increasing freedom applied in the treatment of inflammatory conditions involving the pleura. It has finally become a recognized means of treatment

in certain forms of localized and chronic peritonitis, especially when purulent collections have formed. Mr. Treves urged the adoption of this principle in treatment in connection with acute and diffused forms of peritonitis. A female, aged 21, was admitted into the London Hospital January 21st, suffering from chronic pelvic peritonitis, following severe gonorrhœa. On February 25th, three months after the commencement of the chronic peritonitis, she suddenly developed the symptoms of acute diffused peritoneal inflammation. The sequel showed that a large chronic purulent collection, containing very offensive matter, had formed near the left pelvic brim. The The walls of the abscess were formed partly by the pelvic peritoneum and partly by many coils of small intestine that had become matted together. The acute symptoms were due to the bursting of this abscess and the extravasation of its contents into the general peritoneal cavity. Oh February 26th the abdomen was opened under antiseptic precautions, the patient being at the time apparently in a very critical condition. The general surface of the peritoneum showed the ordinary appearances of acute peritonitis. The intestines, where in contact, were highly glued together. A quantity of semi-opaque fluid mixed with flakes of lymph and pus escaped. The whole peritoneal cavity was washed out with many quarts of water and a drain introduced. The patient made a good recovery, and was allowed in the garden on the fortieth day. Mr. Treves alluded to several cases in which operations involving laparotomy have been performed with success during the progress of acute peritonitis, the cases having been in most instances the subject of error in diagnosis. Allusion was also made to the recent experiments of Dr. Parkes of Chicago, as to the treatment of penetrating gun-shot wounds of the abdomen with perforation. Mr. Treves ventured to suggest the use of abdominal section in the treatment of certain cases of acute general peritonitis such as that following injury, gun-shot wounds, the bursting of an abscess, and specified cases of perforation.—*Frederick Treves*, F.R.C.S., in *Proc. of Royal Med. and Chir. Society*, *Brit. Med. Jour.*, March 14th.

Does Smoking Cause Cancer?—A little knowledge of pathology is sufficient to demonstrate that smoking cannot cause cancer, although the irritation of a pipe sometimes sets up ulceration of the lip, which, when of very long standing, may become cancerous, provided that the patient has a hereditary tendency to cancer. There is no evidence whatever that cigar-smoking causes cancer of the tongue. Mr. Butlin, the author of some of the most recent observations and statistics on cancer of the tongue, has shown that the proportion of men to women suffering from that disease is nearly 6 to 1, but that it occurs in men who neither drink nor smoke, whilst it is as rare among women of the most masculine habits as amongst other females. Even the irritation of a broken or decaying tooth can only be an occasional exciting cause, since this condition is as common amongst women as amongst men, whilst cancer of the tongue is, fortunately, rare, out of all proportion to cases of decayed teeth. There can be no doubt that a man with a tooth irritating his tongue ought to have it removed. It is equally certain that no smoker, who has a sore on his tongue, ought to persist in the use of tobacco until that sore is cured. But the risk of cancer through smoking is so infinitesimal as to be perfectly useless as an argument for the anti-tobacconists.—*Brit. Med. Jour.*, March 14th.

Chloral in the Convulsions of Children.—Dr. Henry Dwight Chapin discusses, in the *American Journal of Obstetrics*, December, 1884, the relative merits of chloral and morphine in the convulsions of children. He believes that while morphia will, in many cases, control the convulsions, yet it is an extremely dangerous remedy, tending to hurry the congested brain into a fatal stupor. He strongly advocates the rectal injection of chloral. He has seen many cases, as critical as those in which the morphine was given subcutaneously, yield almost as quickly to chloral administered by the rectum, as doubtless have many others who have thus employed the latter. Some weeks ago he was called late at night to see a baby fifteen months old, who had been in a convulsion over an hour. The infant was lying in a deep stupor, with jaws tightly set, thumbs pressed into the palms, and having convulsive seizures every few hours. He tried in vain to pry open the teeth and get down a solution of potassium bromide. An enema was next given, although the

mother positively stated that no indigestible substance had been taken. No fecal matter came away, and the water remained in the bowel; as no time was to be lost in waiting for it to be expelled, he at once injected five grains of chlorol in solution into the rectum. The convulsive movements soon became less violent, and with longer intervals between. The chloral was repeated several times, and the convulsions soon stopped entirely. The stupor remained, but in several hours it was gradually replaced by a natural sleep, and the next morning the baby was quite bright, although looking pale. In this case he could find no cause for the convulsions, but thinks if sufficient morphine had been given to control them the stupor would have ended fatally.—*Med. and Surg. Rep.*

Cocaine hydrochlorate in Otalgia due to Catarrhal Inflammation of the Ear.—Dr. Henry Reder, of Aurora, Ill., writes the *Therapeutic Gazette*: "After treating a case of severe otalgia with all ordinary remedies, including the hot-water douches, leeches to the tongue, and paracentesis of the membrana tympani, without much relief, I thought of cocaine hydrochlorate. I inserted into the vial of the atomizing tube of a Codman & Shurtleff steam atomizer a four per cent. solution, and advised the patient to fill her mouth with the spray, close her lips, expand her cheeks, and so force the vapor into the eustachian tubes; this was repeated at intervals of three minutes. I then adjusted the nasal tube of the atomizer, inserted it into the external auditory meatus, and also sprayed the external canal at intervals of three minutes. After fifteen minutes from the last application the patient was wholly relieved, and passed a comfortable night."

Shall the Physician Frankly tell the Consumptive Patient that his Disease is Phthisis?—It is still the opinion of many eminent medical men that we should, as a rule, not do so. As long as phthisis was considered an incurable disease, there may have been some reason for such concealment; but now, as we know and can tell our patients that it is curable, I think they ought to be informed of their condition more or less according to the individuality; and as far as my experience goes this has a salutary effect. The patient is more ready to co-operate with the physician and to bring the great and long continued sacrifices, for he becomes aware of his own large share of responsibility. I have already alluded to the circumstance that intelligence on the part of the patient and his friends is a great help towards recovery in phthisis; and that want of judgment or insight into the nature of the illness and of the manifold dangers, and into the means of care, renders the prognosis less hopeful unless we are able to place the strictest superintence of a judicious physician, or still better in a health establishment under the control of a resident medical man and his assistants, or in a well-arranged special hospital. Every consumptive patient ought to be under the eonstant guidance of his doctor.—*Dr. Hermann Weber, Cromiam Lecture, Brit. Med. Jour.*, March 21.

Cleanliness in Labor Cases.—Dr. W. O. Stillman, of Albany, N.Y., writes to the *Med. and Surg. Reporter* as follows:

In the number of the *Reporter* for January 24th, reference is made to an article by Dr. G. H. Balleray in the *American Journal of the Med. Sciences*, and the treatment which he suggests for labor complicated with concurrent erysipelas. Cleanliness appears to be his principal precaution.

In the lying-in department of the Vienna Algemeine Krankenhaus some 10,000 deliveries occur annually, and the elaborate precautions which are observed to prevent septic infection, together with the marked freedom from the same which has been the result offer suggestions to the general practitioner in the treatment of all puerperal cases. The necessity of cleanliness in attending labor was long ago insisted upon. The extent to which it shall be carried is perhaps debatable. It would seem that it is quite as necessary for the general practitioner going from bedside to bedside, from autopsies, low fevers, etc., to the woman ready for delivery, as for the specialist or student in his ward.

Perhaps the antiseptic methods used in Vienna may be of interest and not generally known here. In Prof. Carl Braun's ward, for instance, before examining a case, or attempting delivery, the hands must

1. Be washed with soap and water, and well-scrubbed with a stiff brush, especially the finger nails.

2. They must be dipped into a five (5) per cent. solution of permanganate of potassa, and

3. Passed through the same process with a solution of from two to five per cent. of oxalic acid, which decolorizes the permanganate stain on the hands.

4, and finally, the hands are washed in a solution of carbolic acid, of a five per cent. strength, and are then ready for the vaseline and an examination.

As soon as the after-birth has been delivered the vagina is washed out, high up, with a two per cent. solution of carbolic acid at the temperature of the room. About one gallon of the solution is used, and the injection is given by means of a huge glass fountain syringe. Almost as soon as the child is born, and often before the cord is cut, its eyes are syringed out with a two per cent. solution of nitrate of silver.

A more thorough antisepsis can hardly be conceived of, and the results seem to justify the trouble, though I cannot at this moment lay my hands on the statistics of the hospital.

ERRATA.—In Dr. J. I. Pennington's paper, published in the issue of April 4th, the following errors occurs: On page 432, second column, thirty-seventh line, read *inhibit* in place of *exhibit*. On page 439, first column, twenty-seventh line, read *tinc. card. compd.* in place of *tinc. card. lev.*, and in fifth line from bottom read *relaxes* in place of *relieves*.

Medical Items.

Persons afflicted with consumption. especially the subacute forms, ought not to be allowed to perform offices by which breath, saliva or sputa are brought into close contact with healthy and still less with young or weak diseased people or persons with an acquired or inherited predisposition. Not without reason physicians have forbidden kissing between consumptive patients and other persons.—*Dr. Hermrnn Weber's Cromiam Lectures.*

Dr. Joshua Wilson, one of the oldest physicians in this State, died at his residence in Harford county during the past week. Dr. Wilson was 89 years old. He graduated from the University of Maryland in 1818.

The British Gynecological Society held its first meeting March 11th. The *British Journal of Gynecology*, issued by this Society, will appear April 10th.

Prof. Doremus, the distinguished New York chemist, is said to have an income of $25,000 per annum from chemical analyses of patent medicines and other similar articles.

Dr. O. G. Darling, of Brooklyn, N. Y., in the *Ther. Gaz.*, claims that mur. of ammonia in half drachm doses, every half hour, if necessary, until three or four doses have been taken, is a specific for facial neuralgia. He is in the habit of continuing the remedy in smaller doses, say ten grains three or four times a day for a day or two after the neuralgia subsides. It is also valuable for toothache.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, from March 31, 1885, to April 6, 1885.

Gardiner, John de B. W., Capt. and Assist. Surg. Ordered for temporary duty at Ft. McHenry, Maryland.

Carter, E. C., 1st Lt. and Asst. Surg. Granted 1 month's leave with permission to apply for 1 month's extension, to take effect upon the arrival of another medical officer at his post.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U. S. MARINE HOSPITAL SERVICE FOR THE WEEK ENDING APRIL 4, 1885.

Murray, R. D., Surgeon. Granted leave of absence for one week. March 31, 1885.

Bratton, W. D., Assistant Surgeon. To proceed to New York, N. Y., for temporary duty. April 2, 1885.

Watkins, R. B., Assistant Surgeon. To proceed to New Orleans, La., for temporary duty. April 2, 1885.

APPOINTMENTS.

The following candidates having passed the examination required by the Regulations, were appointed Assistant Surgeons by the Secretary of the Treasury, April 1, 1885, viz.:

William D. Bratton, M.D., of South Carolina, and Ralph B. Watkins, M.D., of Connecticut.

Original Articles.

FACTS SERVING TO PROVE THE CONTAGIOUSNESS OF TUBERCULOSIS; WITH RESULTS OF EXPERIMENTS WITH GERM TRAPS USED IN DETECTING TUBERCLE-BACILLI IN THE AIR OF PLACES OF PUBLIC RESORT, AND A DESCRIPTION OF APPARATUS.*

BY W. H. WEBB, M. D., OF PHILA.

It is in accord with the spirit of the age to attempt to get at the root of all things affecting the health of our race. The causes of tuberculosis and influences modifying the progress of the malady claim not only the active interest of those engaged in the field of scientific medical investigation, but the attention of every mind that fully appreciates the universal prevalence and immense mortality resulting from the scourge consumption. It may add somewhat to the interest, if not to the elucidation, of this subject to trace the progress of thought springing from the observation of clinicians of all ages. By collecting the expressions of the *master-workmen* of different times, we will see that knowledge upon the subject has been steadily progressive, and that what now seem to be proven facts, have been preceded by flashes of truth in almost every epoch of medical history. The discovery of the tubercle-bacillus was not drawn from the inspiration of genius, but from the shaping of clinical facts gathered in the progress of our art, from the time of the Father of Medicine until the day that Koch discovered a peculiar microbe in tuberculous patients.

The word tubercle was used by Hippocrates,† but he applied it principally to designate small external tumors—Phymatæ—as, hordeolum, furunculus, sycosis, anthrax, wheals, etc. It is said that the word was used by Celsus, about A. D. 20, but no special meaning was attached to it by him.

Franciscus Delebœ Sylvius, who lived between 1614 and 1672, was not only a strong advocate of the doctrines of Hippocrates, but also did much to advance the knowledge of this disease. He was the first to use the word tubercle in designating the hard nodules found in the lungs of the phthisical. He was also the first to speak of the formation of cavities and destruction of the lung tissue by the softening and breaking down of these hard masses. He describes three kinds of consumption—one of the blood; one of the lungs, occasioned by bad nutrition; and one of degenerated glands. Through this latter proposition he may be regarded as the originator of the theory of a relationship between consumption and scrophulosis. "He believed that in the predisposed the disease may be excited by contagion."*

As a result of autopsies made by Willis, and also by Bonetus, about from 1640 to 1670, the subject of phthisis was very much advanced.

When Richard Morton's† celebrated work appeared, the opinions set forth therein were not only greatly in advance of those of his own time, but were destined to supplant all others, and to be accepted as correct for more than one hundred years after his death. He asserted that all consumption originated through tubercles, and that they gave rise to the dry cough. The idea entertained by Hippocrates, that consumption was due to inflammation and ulceration, he strongly opposed. He also declared that he believed the disease to be propagated by infection. "For," said he, "this distemper—as I have observed by frequent experience—like a contagious fever, does infect those that lie with the sick person with a certain taint." (p. 67).

Desault‖ also insisted that tubercles were the essence of consumption, and that ulceration of the lungs and hæmoptysis were the result of the deposit. He believed in the contagiousness of the disease when ulceration had occurred. A statement, which at this day seems to have been almost prophetic, occurs in his writings upon tuberculosis: "Worms," he declares, occasioned by the putrefying lungs, "propagate the disease and cause it to spread."

From the time of Morton to 1793, the subject of tuberculosis commanded the attention of some of the most distinguished men in medicine. (Sydenham, F. Hoffman,

---

* Read before the College of Physicians of Philadelphia, February 4th, 1885.

† "The Genuine Works of Hippocrates." Published by the Sydenham Society. London, 1849.

* Quoted in "A Practical and Historical Treatise of Consumptive Diseases." By Thomas Young, M. D., 1815, p. 178.

† Phthisiologia, or a Treatise of Consumption." 2d Ed. London, 1694.

‖ Quoted by Thomas Young, M. D. Loc. cit.

Boerhaave, Van Swieten, Sauvages, Morgagni, Cullin, Hufeland, Portal, Stark, Ruysch, Stahl, Reid and Baumé). At this time Baillie's great work appeared,* in which he demonstrated the existence of tubercles in other organs besides the lungs.

Bayle,† an independent worker as well as thinker, insisted most strenuously that phthisis is a general chronic disease, and owes its origin to a special principle—the tuberculous. He, too, denied most positively the teachings of Hippocrates, that consumption was due to inflammation and ulceration. To him is due the credit of discovering what is now known as miliary tuberculosis. "Out of nine hundred autopsies performed by him, he found 624 had tubercular phthisis, 185 the granular or miliary tubercle; 72 melanotic, 14 ulcerous, 4 the calculous, and 3 the cancerous." He says further: "This disease appears always to depend on a peculiarity of constitution. Hæmoptysis is a frequent symptom of consumption, and is sometimes mistaken for its cause; but it often happens that when hæmoptysis has been fatal, the lungs are found full of tubercles."

Lænnec, who followed Bayle, declared that all consumptions, including scrophulosis, were nothing but the consequences of the tuberculous specific principle, which might be inherited or be acquired. In demonstrating his theory he made use of auscultation, which it is said he originated, in accurately determining the diseased condition of the lungs. Lænnec's views in regard to the pathology of consumption, notwithstanding he had very strong opponents among his colleagues, were held for a long time. Schönlein, in the main, held with Lænnec, but differed most positively with him in making a marked distinction between tuberculosis and scrophulosis. At this time scores of eminent investigators were busy with this subject, and the confusion of ideas that then existed occasioned the promulgation of many divergent theories; thus were described tuberculization of pus, tuberculous pus, gray tubercle, yellow tubercle, gray infiltration, tubercle granules, tubercle corpuscles, granulosis, albuminous tubercle, etc., etc. Indeed, the number of forms assumed by this disease was limited only by the number of writers upon it. This tended to give to the simplicity of the theories advanced by Lænnec a great attraction to many, who held to them for sheer comfort of mind. Out of this dire confusion a way was opened by Virchow, whose cellular pathology gave us a positive science by which the theories of previous writers were exploded.

In the early part of 1882 Dr. Koch made his name immortal by giving to the world the result of the researches and experiments[1] by which he swept away all false ideas that had existed in regard to tuberculosis for a period of over two thousand years. It was then that he made the announcement that "Tuberculosis is a specific, infectious disease, caused by a specific micro-organism—the bacillus tuberculosis—which constitutes, in fact, the true tubercle virus." This statement is one of the most remarkable, in its import, in the history of medicine.

Koch reached this position by the results obtained from experiments made with the tubercle-bacilli which he had artificially cultivated. He prepared a nutritive substance and introduced into it a speck of pus taken from a tuberculous human lung. In this way he obtained a number of bacilli, with which he infected fresh material, and by frequent repetition of this process, which he carried on for many months, he succeeded in obtaining bacilli very many generations removed from those taken from the diseased lung. These cultivated bacilli were introduced into the circulation of healthy animals, and in every instance induced tuberculosis. Tubercles in large numbers were found in the lungs, liver and spleen of all the animals thus experimented upon.

The labors of the illustrious Pasteur, of France, and of Koch, of Germany, are now well known to us all. They are the leaders of a host of equally zealous investigators who have acquired more or less distinction through their efforts in this direction.

Villemin,* Buhl,† Bollinger,‡ Fraenztel,§ Balmer,‖ Ruhle of Bonn,¶ Lichtheim,[2]

*"Morbid Anatomy." London, 1793.

†"Recherches sur la Phthisis." Paris, 1810, p. 66. Quoted by Dr. Young. Loc. cit., p. 452.

1Die Etiologie der Tuberculose. Berliner Klin. Wochenschrift, 1882, No. 15.

*Gazette Med. de Paris, Dec., 1865. Also "Etudes La Tuberculose." Paris, 1868.

†Lungenentzundung, Tuberculose und Schwindsucht. 1873.

‡Archiv. f. Experim. Pathologie, Bd. I. 1883. Also N. Y. Med. Record, March, 1884.

§Berliner Klin. Wochenschrift, 1882. No. 45.

‖Ibid.

¶Medical Record, New York, May, 1888.

2 Ibid.

the late Prof. Cohnheim,† Gaffky,‡ Ewald,§ Ehrlich,‖ Kowalski,¶ Wilson Fox,* Cheyne,[1] Shakespeare,[2] Sternberg,[3] Ernst,[4] Colin,[5] Tappeiner,[6] Williams[7] and others, sacrificing, earnest and conscientious workers, banded together in the interests of science and of their fellow-men, and inspired by the hope of being able at some future day to stay the progress of a malady which has been the occasion of more deaths than all the epidemics of disease, and all the disasters by land and sea; not only command the attention and support of the scientific world, but also the gratitude of every intelligent human being.

With a rapid but steady space those observers are advancing on the road which will soon lead to the desired goal. The clouds of error are being dissipated by newly discovered truths, and to-day the subject of Tubercular Phthisis is better understood than ever before. It is my purpose this evening to bring to the notice of the Fellows of the College some facts by which, I think, the Contagiousness of Tuberculosis is clearly demonstrated.

Careful researches by DeQuartrefages,[8] Cook,[9] Livingston,[10] Rush,[11] Budd,[12] and others, seem to prove that tuberculosis first appeared among the inhabitants of Europe, and gradually manifested itself in those parts of the world with which they had intercourse. If this is true, it is one of the best evidences of the contagiousness of phthisis.

A contagious or infectious disease can have but one cause, and this is eminently true of Tuberculosis, which does not arise from a variety of causes, but is solely due to the tubercle-bacillus. Wherever this bacillus finds it proper nidus it will there develop and multiply; and, if this should be in living animals or human beings, the progress of the disease will be determined by the character and amount of food offered for the growth of this germ; thus with a nidus rich and plentiful we may have a case of acute phthisis lasting not more than thirteen days¶ and, on the other hand, if the pabulum is poor and scant, the case may be a chronic one extending over period of twenty-five years, such a case having occurred in my own practice.

The bacilli may enter the system through the lungs or by the stomach. The air we breathe, as well as the food we take, especially in the vicinity of the phthisical, may be laden with these germs. The air of the ventilating flues at the Brompton Hospital, when carefully examined, was found to contain tubercle bacilli in fair abundance.* The sputa of tuberculous patients drying upon our streets is ground into an impalpable powder by the feet of pedestrians, and is then disseminated through the air to be inhaled alike by the healthy as well as those predisposed to tuberculosis. Such sputa, mixed with the dirt of the street, have been collected, dried and powdered again, at frequent intervals during a period of several months. Guineapigs were then inoculated with this matter and in a short time the animals thus treated died from tuberculosis.‡

To admit that the tubercle-bacillus is a pathological product is to express a belief in spontaneous generation,† and I feel sure that none of my enlightened hearers are prepared to subscribe to that doctrine.

It is asserted, by some pathologists, that other matter or irritant than the tubercle-bacillus is capable of producing the disease. This idea is not a new one, for Richard Morton says: "Chalky stones that are preternaturally bred in the lungs, or nails, and other hard bodies, slipping down into the lungs, when persons laugh, are to be recorded among the causes of a consumption of the lungs;"‡ and he narrates a case, p. 247.

It is also claimed by a number of writers that certain callings or occupations may be a cause of tuberculosis, owing to fine particles of dust inhaled by those employed. Thus coal miners, dry grinders, stone cut-

†"Consumption as a Contagious Disease," London, 1880. Translated by H. D. Cullimore.
‡Report of the Imperial Health Office, Berlin, 1884. See Review of Amer. Jour. of the Med. Sci., July, 1884.
§Med. News, Phila., Sept. 6, 1884, p. 275.
‖Deutsche Med. Wochenschrift, No. 19, 1882.
¶Wiener Medizinische Presse, Feb. 24, 1883.
*Med. Times and Gazette, London, 1883, vol. II, p. 672.
1 Pratitioner, London, 1883, vol. XXX.
2 Proceedings of the Phila. Co. Med. Society, 1884, pp. 315, 320.
3 Medical Record, New York, Oct., 1884.
4 Amer. Jour. of the Med. Sci., Oct., 1884.
5 Med. Centralblatt, 1873, No. 30.
6 Virchow's Archiv, Bd. 82, 1880.
7 The Lancet, London, Feb. 24 and July 28, 1883.
8 The Human Species, by A. DeQuatrefages, N. Y., 1883, pp. 428, 430.
9 Ibid.
10 Ibid.
11 Medical Inquiries & Observations. Phila., 1789, p. 137.
12 The Lancet. London, 1867. Vol. II, pp. 451, 452.

¶Medical Diagnosis, by J. M. Da Costa, M. D., LL.D. 6th Ed. Phila., 1884, p. 320.
*The Lancet. London, July 28, 1883.
‡Med. and Surg. Reporter. Phila., 1884, Vol. I, p. 697.
†Floating-matter of the Air. By John Tyndall, M. D. New York, 1882, pp. 277, 320.
‡Loc. cit., p. 67.

ters, moulders, operatives in cotton and woolen mills, etc., are apt to have the disease. But those who believed that the dust breathed by individuals engaged in these occupations might occasion phthisis were evidently oblivious of the fact that the air carried, in the form of germs, far more potent factors; and that while the dust may have produced an irritation of the air passages, the presence of the tubercle-bacilli was essential to the production of the disease. The inhalation of irritants, or lowered vitality, occasioned by certain occupations, may cause the predisposition, but they are never the cause of the disease *per se.*

Not all the predisposing causes united could in any instance induce tuberculosis without the advent of the tubercle-bacillus. That something more is needed was admitted by Pollock twenty years ago, when he declared that there must be "some subtle agent to precipitate, concentrate, and shape these elements of disease into tubercle.§ And Da Costa says, "whatever it be, is something special.‖

Experiments have demonstrated, beyond doubt, that it is impossible to induce true tuberculosis in any case where proper precautions have been taken to remove from the irritant used all living germs. This is now accepted as a fact by many of those who once held a contrary opinion. Wilson Fox, Cheyne, Sternberg and others, who performed these experiments under the conditions mentioned, have acknowledged that under such circumstances it was impossible to produce the disease.

Objections are also made to the fact that these bacilli are the case of tubercle, because they were not found in all the cases of tuberculosis examined by certain investigators. It is fair to presume that in these instances they must have escaped detection, since bacilli have been found in every case of tuberculosis examined by careful observers.

Many instances are recorded where foreign bodies have beeu carried into the lungs by gunshot wounds or otherwise, without occasioning much disturbance in the parts or seriously affecting the health.

Rush,¶ with his experience of the Revolutionary war, declared that he had never known a case of phthisis to result from wounds in the lungs, and this observation was supported by the Surgeon-General of the Royal Army.

A number of cases of gunshot wounds of the lungs occurred during the late war, but, as far as known, they were not the occasion of any death by phthisis.*

I am free to admit that, in cases where a predisposition exists, it may be still further developed by the presence of an irritant, just as a furuncle in one individual may be harmless, and in another the starting point of a cancer. The late General Baxter,† of this city, received a wound in the lungs on the 6th of May, 1864, and was more or less actively engaged in his duties until twelve years afterwards, when, during a fit of coughing, he ejected what appeared to be a hardened bit of pus. This, upon examination, proved to be the envelope of a small piece of coarse, red cloth, half an inch in diameter (such as is used for the stiffening and padding of coats), which had been carried into his lungs at the time he received the wound in 1864. During all this interval there had been a constant suppuration of the lungs, occasioning considerable discomfort, but not sufficient to render him unable to fill several important positions demanding his careful attention. Three years after expelling the foreign body (seventeen years from the time he received the wound) he died, it is said, from phthisis. In this instance, admitting that he died from phthisis, a predisposition to the disease was evidently established by a greatly lowered vitality, occasioned by the long continued suppuration. For twelve years he lived without a sign of phthisis; but after he had rid his lungs of the original irritant, the bacillus tuberculosis found its way to the rich soil so long prepared for its reception, and there multiplied until the life of the individual ended.

So certain diseases, occasioning an irritation or a lowered vitality of the pulmonary mucous membrane, have the reputation of being the indirect cause of tuberculosis. Measles, especially when occurring in chil-

§ The Elements of Prognosis in Consumption. London, 1865, p. 337.

‖ Phila. Med. Times, June 19, 1880.

¶ Medical Inquiries and Observations. Phila., 1805, Vol. II, pp. 72, 73.

[NOTE. That the excretion of these bacilli might prove to be the *materies morbi*, was suggested by me some time ago; and this opinion is also entertained by Dr. G. M. Sternberg, U. S. A, who subsequently made the same suggestion in the *Med. Record*, N. Y., Oct. 25th, 1884].

* Med. and Surg. Hist. of the War. Second issue, 1875, Part I, Surg. Vol., pp. 478, 481.

† The Daily Evening Telegraph, Phila May 10th, 1881.

dren of phthisical parents, is liable to leave consumption as a sequel. The mucous membranes are implicated in this disease, probably more so than in any of the eruptive fevers; the epithelium is cast off, and the denuded membrane exposed to the direct contact of the tubercle-bacillus.

(*To be Continued.*)

ACTION OF THE MURIATE OF COCAINE ON THE TEMPERATURE NERVES.

BY HENRY HERBERT DONALDSON, A. B., OF THE JOHNS HOPKINS UNIVERSITY, BALTIMORE.

Recent investigation has made it extremely probably that the dermal sensations of heat, cold, pressure tickling and pain are all mediated by separate nerves. This being the case, it would seem not improbable that we might in some way abolish certain of these sensations from a given locality while leaving the others intact. In point of fact by means of the muriate of cocaine the sensations of pressure and pain can be abolished from the conjunctiva while those of temperature remain. My attention was first called to this fact by Dr. Wm. Warfield, who noted in an operation by Dr. Russell Murdoch that the patient recognized the pressure of the instrument on the eye as cold objects, though he felt neither contact nor pain, these sensations having been removed by cocaine.

Being engaged in the study of the sensations of temperature, I spoke to Dr. Murdoch on the subject, and was allowed, by his courtesy, to examine the eyes of two patients at the Baltimore Eye and Ear Hospital with reference to this point. When the eye was completely insensitive to pain or pressure, a small metal point was cooled or heated in water—the temperature being at 10°c. for the cold and 40°c. for the warm—and then rested in the conjunctiva, and the patient was requested to state whether the point was hot or cold, —the answers were all correct—hot and cold being readily distinguished. Later, I put a 5 per cent. solution in my own eye, and found the same thing when it was tested by another person.

Thus far attempts to get the same results from the skin have been in vain, but experiments will be further made on that point.

What I wish to call attention to is the beautiful isolation of the temperature sensations which can be effected in the eye by means of cocaine. I should be very glad to get any clinical facts whatsoever bearing on this question, especially from those who have occasion to use cocaine in the throat.

Clinical Notes.

AN INSTANCE OF THE INJECTION OF ABOUT THIRTEEN GRAINS OF MORPHIÆ SULPHAS, FOLLOWED BY RECOVERY.

Dr. A. L. Hodgdon of Farmwell, Va., writes: The following case took place in one of our large cities:—Mr. C., experiencing some general malaise, was advised by his friend, Mr. P., to take a dose of morphia and quinia, to which Mr. C. consented, and (what was supposed to be quinia) was immediately procured from a neighboring drug store. Thirty grains of the supposed quinia were purchased, and Mr. P. divided the amount and administered nearly half of the same in combination with about ½ gr. of morphiæ sulph., which he had in his possession. After taking the dose Mr. C. lay down upon the bed, and, as near as I could ascertain, (not being present at the time that Mr. P. came in, and gave him the dose, nor for some time afterwards) in about thirty minutes after taking the same he suddenly fell into a state of unconsciousness, and after remaining in that state for possibly an hour, he became conscious, and remained so for a few minutes, when he again became wrapped in the arms of Morpheus. The dose of supposed quinia was taken near noon-time, and when the case came under my observation it was two or three hours after that time. It strongly simulated a case of uræmia, or severe congestion of the brain. Some urine was drawn off by means of a catheter, and upon heating it over the gas a faint cloudiness was observed, probably due to phosphates. Nitric acid was not at hand. About that time heart failure seemed imminent, and a hypodermic of $NH_4HO + C_2H_5HO$ was administered, after which the pulse seemed to improve. Two or three times this injection was adopted with a view to supporting the heart; after which some hypodermics of whiskey were given. At about 7 P. M.

he lapsed into such a condition that the tongue had to be supported through the medium of artery forceps; then bleeding was adopted, the basilic and cephalic veins of one arm were both opened, yet hardly a drop of blood escaped. The arm was then put through a series of milking manipulations, and in some ten or fifteen minutes the blood started to flow, and a fair amount was abstracted, after which the patient sat up in bed for five or six minutes with an expression of bewilderment upon his face. In a short time he lay down, and was unconscious once more. About midnight the phenomena were such that narcosis from morphia could no longer be doubted. The respiration finally went down from five to four per minute, and at this juncture a Faradic battery was being placed in readinesss, but its use was not necessitated as the respiration improved, and by 8 or 9 o'clock in the morning Mr. C. was quite himself again, and requested Mr. P. to give him another dose of quinia, which Mr. P. was loath to do, as he had discovered that the supposed quiniæ sulph. was labelled morphiæ sulph.; so a good dose of an efficient purgative was administered in place of the other. The question is how did Mr. C. recover from so large a dose of morphiæ sulph. as that mentioned. We know that ammonium hydrate precipitates morphiæ sulph. in aqueous solution:—$(C_{17}H_{19}NO_3)_2 H_2SO_4 5H_2O + 2NH_4HO = (NH_4)_2 SO_4 + (C_{17}H_{19}NO_3)_2 + 7H_2O$. Is it possible that a reaction, something of like nature might have taken place within the economy, and if so why might not other alkaloids behave in the same manner with a similar reagent?

In the case just named no emetic was taken whatever, and a purgative was not exhibited before the party was quite himself again.

Dr. N. S. Davis, the veteran editor of the *Journal of the American Medical Association*, has expressed a determination not to continue his work as the editor of this journal after this year. Dr. Davis has inaugurated and conducted this journal under peculiarly trying circumstances. As was to be expected, the journal has been harshly criticised, but in point of fact it has not merited the abuse heaped upon it. It is far easier to find fault with a medical publication than it is to conduct one.

Society Reports

OBSTETRICAL SOCIETY OF PHILADELPHIA.

STATED MEETING HELD, APRIL 2, 1885.

The President, B. F. Baer, M.D., in the Chair.

The President exhibited the specimen and reported the case of a rapidly growing

OVARIAN CYST.

A patient of Dr. A. G. Walls, of Lock Haven, Pa., M. L., æt. 26, single, puberty at 14, always well, and possessed of a remarkably fine physique, tall and robust, felt some pain and uneasiness in the ovarian region three months ago. She was examined by Dr. Walls, who found the right ovary enlarged to the size of a large orange. She soon after found that her abdomen was increasing in size.

On March 9th I saw her; she was beginning to show facial signs of ovarian disease in slight emaciation, palor, and the peculiar distress of countenance. The menses were regular; the abdomen was distended to the size of the eighth month of pregnancy and was perfectly symmetrical, pyriform in shape, dull on percussion, with a resonant corona extending around from one flank to the other; and there was marked fluctuation. Vagina virginal, cervix uteri pointing slightly forwards, body retroverted and mobile. The lower border of the abdominal tumor could be touched per vaginam. The uterus was not affected by the movement of the tumor. *Diagnosis.*—Ovarian cystoma. Immediate removal advised. *Operation.*—Assisted by Drs. Walls, Hayes, and Lichtenthaler; in the presence of Drs. Watson and Ball. Incision, two and a-half inches; fat in abdominal wall at least an inch in thickness. Tapped the cyst, which contained a bucketfull of a thick fluid the color of pus. Removed the collapsed tumor through the small incision—there were no adhesions—ligatured the short pedicle and dropped it. The left ovary was found to be as large as a walnut and undergoing polycystic degeneration; it was also removed. The incision was closed with six silk sutures. The patient recovered without an untoward symptom.

The rapidity of the development of this tumor was remarkable and justified me in

bringing it before you. The other ovary is a beautiful specimen of beginning polycystic disease. It is a curious fact that of my last six ovariotomies, in not one of them did the period of development extend over nine months from the time the disease was first discovered. One of them only three months as just reported, from the time it was found by Dr. Walls to be the size of an orange. They were all good-sized tumors, two of them weighing nearly forty pounds each.

THE BROMIDE OF ETHYL AS AN ANÆSTHETIC IN LABOR.

(The entire paper will be published in the *American Journal of Obstetrics*).

Dr. Montgomery, reviewing the various anæsthetics, said chloroform is objectionable in that it causes inertia-uteri and tedious labor, and increases the danger of post-partum hemorrhage. The relatively infrequent fatal cases under its use in surgical practice, and the still more rarely serious results from its use in obstetrics, forbid its habitual use. The use of ether in natural labor is infrequent because to relieve pain the patient must be profoundly etherized. Partial etherization but destroys the ability to bear pain without obtunding sensation. Besides, Tait has demonstrated that ether passes rapidly into the circulation of the fetus, endangering its existence. The mixture of nitrous oxide and air, advocated by Klikowitsch, requires a special apparatus and is unwieldly. The ideal anæsthetic is one that is safe for mother and child, certain in its effects, rapid in relieving pain without producing loss of consciousness and whose effects pass off quickly. All these demands are met by the bromide of ethyl. He enumerated 112 cases in which it had been used, twenty-nine of which were in his own practice; none of the mothers died and but three of the children. In none of the latter could death be attributed to its use. It was administered during the second stage of labor by placing a napkin, wet with a few drops of the ethyl, over the face of the patient at the advent of each pain and withdrawing it as the pain subsided. Unless a drachm was used the sensation of pain was obtunded without arresting consciousness. The process of labor was carried forward vigorously and quietly, the patient ready to exert or withhold voluntary aid as her attendant might direct, and the expulsion of the head was attended by no greater pain than accompanies the evacuation of obstinately constipated bowels. His experience did not lead him to believe that its use would induce inertia-uteri or increase the tendency to post-partum hemorrhage.

Dr. D. M. Barr is much interested in this subject, and thinks from this report that the indications for the usefulness of bromide of ethyl are favorable. He would like to know to what degree the patient returned to consciousness between pains. He will use bromide of ethyl as an experiment; but he will say here that his old combination still gives him the very best effects with perfect safety. He has continued to use it in almost every case of labor since his report on anæsthetics in labor. (See *Med. and Surg. Reporter*, March 13, 1880). He would feel some hesitation in using the bromide of ethyl as it is dangerous, even if not so much so as chloroform. How would it act if mixed with ether? The objectionable qualities of chloroform and ether balance and overcome each other, and the addition of alcohol to the mixture prevents their explosive action, so to say, that is the sudden effect of a full and deep inspiration of the strong vapor of the anæsthetics is prevented by the admixture of alcohol in the proportion of chloroform one part by measure, ether three parts and alcohol two parts. If a portion of this mixture be placed in a saucer and heated it will evaporate together; the ether does not pass off from the alcohol. This mixture soothes the pain and makes the patient happy. The excited or drunken stage of ether is avoided; the danger of chloroform is avoided. Unconsciousness is unnecessary and is not produced. If bromide of ethyl has any of the dangers of chloroform they are unchecked by admixture with correcting agents. Dr. Barr related the particulars of a case in which he had employed his mixture to show how kindly it acted in the presence of suspected functional heart disease. In this case its administration was continued for nine hours; the pain was relieved; there was no vomiting; no effect upon the pulse.

Dr. R. P. Harris remarked that chloroform was considered perfectly safe as an anæsthetic in labor. Playfair, in his last book, advocates it on this ground; but there

have been fatal cases. The danger of an anæsthetic can only be ascertained after it has been used and reported by many observers so as to get an average. Some men are careful and cautious, but all are not. The use of mixed anæsthetics are becoming more general in England.

Dr. W. M. Welch, upon invitation by the President, remarked that he had had no experience with bromide of ethyl and but very little with other anæsthetics. He had given ether in one case and a troublesome condition of intoxication had been developed. He was applying the forceps and the patient suddenly seized one blade and wrenching it out of the vagina tore the vulva. He proposes to get along without the use of anæsthetics.

Dr. Henry Leaman, upon invitation by the President, said that he also had no experience with bromide of ethyl. He does not hesitate to use ether in bad cases of labor, but he does not employ it when he can avoid it. He is not yet convinced that the use of anæsthetics in natural labor is advisable. There has not yet been formulated a satisfactory definition of natural labor. He is now engaged in studying that subject. He has observed in private practice most of the positions described by Engelmann in his papers on primitive obstetric practice. The sympathetic system in labor reacts upon the cerebro-spinal system and produces the condition of nervous excitement, which is seen in patient, and which often extends to the friends of the patient and even to the doctor in charge of the case. After a close observation of over six hundred cases, he thinks labor can be as natural a physiological operation as respiration or the circulation of the blood, or any other function of the body with this one difference that whereas the ordinary performance of function is pleasureable, in labor pleasure is replaced by pain. He is not in favor of the use of anæsthetics merely to remove or obtund this pain as it is natural; and anæsthetics may interfere with the natural process and cause relaxation or retard involution, resulting in that root of endless misery a subinvoluted uterus.

He has been making careful studies with a dynamometer, which measures the available pressure. I believe that it gives the sum of the pressure applied to the ovum expressed in the projection of the advancing part, against which it rests. He will continue these studies which are not yet complete. The force of the accessary muscles, as the diaphragm and abdominal muscles, takes no real part in the expulsion of the fœtus, but merely embraces the uterus, preventing any rebound or loss of force when the ovum impinges against the pelvic walls or perineum. Their action being to sustain or hold the uterus closely to its work. The entire force exerted is not nearly so great as is usually supposed. The force of labor does not exceed that of arterial pressure, which I think is about six pounds. The exit of the child is not violent but gradual. It is a popular belief that a majority of labors occur at night; but, of his six hundred carefully recorded cases an equal number were born between 6 A. M. and 6 P. M., and between 6 P. M. and 6 A. M. There are, however, two acmes, one at 11 P. M. and another between 7 and 8 A. M. These two periods correspond to the times of greatest blood pressure. He ranges himself on the side of those who believe in the non-necessity of the use of anæsthetics in natural labor.

Dr. W. H. Parish would like to hear more particularly from Dr. Montgomery in his closing remarks respecting the safety of bromide of ethyl as an anæsthetic. A few years ago it was introduced into surgical practice in this city, and was abandoned in consequence of its dangerous character. If it is dangerous in surgery why should it not be also in obstetrics? Chloroform, which was at one time considered perfectly harmless in the latter class, has been found to be no safer there than in ordinary cases.

He has established for himself three rules respecting the use of anæsthetics in obstetric cases. 1st. In easy normal cases no anæsthetic is required. 2d. If the patient is nervous, excited and uncontrollable he gives chloroform at the incipiency of each pain, to quiet the excitability of the patient, and take off the sharpness of the pain without producing unconsciousness; during the intervals between pains the chloroform is withheld. 3d. Whenever he considers that unconsciousness, full anæthesia, is necessary he employs ether so as to avoid the depressing effects of chloroform. Bromide of ethyl might be used in place of chloroform, as indicated in his second rule, if shown to be equally safe; but he would not consider it proper to use it to produce complete relaxation as required for version or applica-

tion of the forceps. Prof. Wood, in his experiments, found bromide of ethyl more dangerous than chloroform. Dr. Parish does not now use it, and he fears it would go hard with any physician before our courts if he had a fatal accident occur during its use.

Dr. Baer thought Dr. Leaman's estimate of the force required to extrude a full term fœtus far below the mark. A child weighing seven pounds or over is pushed through a curved, horizontal, resisting passage, with irresistable power, and sometimes rapidity. A force of six pounds would not lacerate a perineum. In some cases there is but slight resistance, and the force required is small, and the pain not severe. He has seen cases moaning from the severity of their pains during parturition. In one case recently a cat was delivered of its first kitten after severe and prolonged pain, and the second kitten required three hours for its extrusion. The pains of labor are more easily alleviated than the pains of surgery by anæsthetics, and with no increase, if not a diminution of danger.

Dr. Montgomery in closing said that as to danger from the use of bromide of ethyl, he thought there was no danger if a pure article was carefully used. The patient is not completely narcotized, consciousness is not lost; the administration of the drug is interrupted. The patient can co-operate although relieved of suffering. She can answer questions. Prof. Müller is the only one who has failed in obtaining good effects, and this was probably due to impurity in the drug. Bromide of ethyl does not take the place of chloroform, nor does it produce muscular relaxation, nor relaxation of the uterus as required in version. It can be pushed to complete unconsciousness, but that is not necessary, as pain will be relieved without, while the contractions of the uterus and respiratory muscles are fully as effective as without it. Labor is undoubtedly a physiological process, as much so as respiration or defecation, but it does hurt. It is the type of the most severe and agonizing suffering, and we, as physicians, are called on to relieve that suffering and prevent the waste of vital force to the extent that we can by preventing pain, long continued pain. Bromide of ethyl is apparently entirely safe when given as I have used it. Experimental physiologists do not all agree with Prof. Wood as to the comparative danger of this and other anæsthetics.

PROCEEDINGS OF THE MEDICAL SOCIETY, DISTRICT OF COLUMBIA.

STATED MEETING HELD FEBRUARY 11TH, 1885.

The Society met with President, Dr. W. W. Johnston in the chair, DR. MCARDLE, Secretary.

Dr. J. Ford Thompson read the report of a case of

ABSCESS OF THE LIVER.

A. S., a tailor, æt 54, native of Germany, long a resident of this city; admitted into Garfield Hospital, December 29, 1884, under care of Dr. Lovejoy.

Early in September "took cold," having considerable pain between the shoulders, in the right shoulder and in epigastric region, but no chill. He had but little cough. The pains increased in severity and extent in the abdominal regions, and he was treated for inflammation of the bowels, as he says, but there was never any dysentery or diarrhœa. He had been confined to his bed since the month of September, 1884.

When admitted, his sufferings were about as indicated above, with sweats, tem. 101–5°, pulse 105, respiration 32. He lay with the most confort upon the right side, and complained very much of the pain in the epigastric and hypochondriac regions. During the next week he continued to get worse. I saw him first Jan. 8th. After careful examination I expressed the opinion that he was suffering from abscess of the liver, although the local symptoms were rather obscure. I could detect no fluctuation or circumscribed enlargement of the liver, but upon measurement of the two sides of the chest at the base, I detected an enlargement of the right side of about an inch. I should say that abscess of the liver was suspected by the attending physician, Dr. Cutts, by whom the case was turned over to me.

Jan. 11 I explored with a hypodermic aspirator, the instrument being introduced in the ninth intercostal space posteriorly, and drew off the syringe full of pus. At this time his tem. was 100–5°, and his respiration very frequent, with copious sweats.

Jan. 13. I operated with the assistance of Dr. Cutts and the house assistants,

using Dieulafoy's aspirator, the instrument inserted at the same spot as the exploration. I used the largest trocar and canula attached to the instrument instead of the needle. Ten ounces of thick, dark brown pus were drawn off; and then, by reversing the action of the instrument, the pus cavity was filled with a 2 per cent. warm solution of carbolic acid and drawn off. This was continued six times, until the solution, when withdrawn, was perfectly clear and clean. No anæsthetic was used, and immediately after the operation the patient expressed himself as much relieved. It was estimated that about 13 ounces altogether had been withdrawn.

During the next week the patient improved very rapidly. His appetite returned, the sweats ceased, and he was sitting up and going about the ward.

Jan. 25. For the last two or three days the patient imagines himself worse, although upon examination I could find no reason for it. He was very anxious for a repetition of the operation, saying that he was certain that the matter was re-collecting, as he felt some of the local symptoms he had experienced before the operation.

Jan. 25. In the presence of the medical class, I explored the liver with the aspirator in the same space as before, although I gave it as my opinion that I should find no pus. The instrument was introduced several inches in the direction of the previous abscess, but it appeared to enter only solid tissue and no matter was obtained. As before no anæsthetic was used.

It was clearly a case of imagination on the part of the patient, for, from this time, nothing more was heard from him in the way of complaint, and on Feb. 3d the patient left the hospital, being considered cured.

Dr. Thomson, continuing, said he had operated a number of times in various ways for abscess of the liver, sometimes successfully, at other times without success. He would not enter into the question of diagnosis. The operation was the most important point. He remembered having spoken disparagingly of the aspirator the last time he reported a case to the Society. On that occasion he had praised the direct incision, the drainage tube, and antiseptic dressings. In this case, however, reported this evening, there was no fluctuation, and a deep incision would have been necessary. When he aspirated in a previous case, he had used an American instrument, which is a poor substitute for Dieulafoy's, as it only evacuates the pus. There is no way of reversing and washing out the abscess. Indeed, he had found great difficulty in thoroughly emptying it. This time he used the French instrument and never has he succeeded so well. In any case where the abscess is pointed externally, it is quite easy to make a direct incision and wash it out. But in obscure cases such a plan is dangerous. There is danger even of setting up a general peritonitis. In the case under consideration, he continued to wash out the sac until the water returned perfectly clean. He thought it would be necessary to aspirate several times; but the patient was relieved at once, and was practically well in two weeks. Dr. Thompson was now inclined to think more favorably of the aspirator. In looking up the literature of the subject, he had not found any abscess of the liver treated exactly as he had treated this one. He, of course, could not say whether he would be so successful in the future.

Dr. Lovejoy said Dr. Thompson had remarked in his paper that the patient was admitted under my care at the Garfield Hospital. He wished to state that it was at the close of his term of service, and as Dr. Hagner would be in attendance in two days more, he left the diagnosis for him to make. If he remembered rightly there was no dullness below the line of ordinary liver dullness. There was, however, considerable dullness above the ordinary line of liver dullness. He first thought there was evidence of pleuritic effusion, but upon further examination concluded it was not so. He thought it due to some solidification in the chest, or some serous or purulent pleural effusion. Liver trouble had suggested itself to his mind, but the man was not jaundiced and no discoloration had existed. As well as Dr. Lovejoy remembered the patient had no pain about his shoulder. Dr. Cutts took charge of the man as Dr. Hagner was not on hand, and he believed Dr. Cutts suspected liver trouble.

Dr. Lovejoy inquired as to rigors or chilly sensations, but the patient had had none. He saw nothing that pointed towards abscess of the liver. He requested Dr. Thompson to examine the case, and

learned afterwards that he had operated.

Dr. Reyburn thought the case under consideration showed the importance of an early operation. The diagnosis is by no means easy, and required careful study. The treatment of abscess of the liver has changed of late years. In India, where abscesses of the liver are of such frequent occurrence, it was not thought advisable to operate. He had operated in seven cases. In one case where he aspirated at first, he afterwards incised and inserted a drainage tube. Where the abscess was deep he would aspirate. When near the surface he would treat it as any other abscess. He had never been fortunate enough to succeed with one tapping. The cause of death is not from the abscess but from exhaustion or septicæmia. He contended therefore that we should operate early. We would not think of leaving empyæmic abscesses without opening them. In reply to the President, he said he had seen patients survive extensive loss of liver sub stance. In cases of multiple abscess the patients die of exhaution.

Dr. Thompson thought such patients suffered from pyæmia.

Dr. Cutts said in regard to this case the most notable symptom was pain in and between the shoulders. He had suffered from pain across the transverse colon, which had been diagnosed neuralgia. There was no fluctuation anywhere, and to the naked eye both sides of the trunk appeared symmetrical. Measurement, however, proved the right side larger. There was no sign or history of jaundice.

Dr. Lovejoy asked if there was pain in the region of the shoulder at the time of admission.

Dr. Cutts replied that it had been complained of sometime previous.

On motion the discussion was closed.

Dr. W. H. Taylor reported a case of

PUERPERAL ECLAMPSIA.

Amelia H., a negro girl, aged 17 years, unmarried, pregnant with her first child, had gone to term, and was taken with convulsions, 9 o'clock A. M., January 2, 1885. I saw her at 10 A. M., when the midwife in charge told me she was in active labor, and was just coming out of the third convulsion. I was told there had been headache and other evidences of constitutional disturbance for one or more days before the occurrence of convulsions.

When I came in she was breathing heavily, and her limbs were still convulsed; her head was turned over the left shoulder; her eyes were turned to the left, and the pupils were dilated; she had bitten her tongue; the pulse was rapid, not very strong and easily compressed; the countenance was slightly bloated in appearance. I was told that she had passed her urine freely and frequently.

As the convulsion passed off I shook her and spoke to her loudly; she tried to turn her eyes in the direction of my voice, and seemed to make an effort to answer my questions; but I do not think she could see, or that she comprehended very perfectly what was said to her. My speaking to her disturbed her, and she presently gathered the bed-clothes about her, and turned on her right side and went to sleep.

On digital examination the head of the child could be felt through the uterus high up above the pelvic brim; the os uteri was directed towards the sacrum, and so high as to be with difficulty reached, and was not sufficiently dilated to admit the tip of the index finger. The examination caused great uneasiness to the patient, and the finger was slightly streaked with blood at its conclusion. This slight show of blood was the only evidence I could discover indicative of labor having set in. I prescribed fifteen grains of chloral hydrate with twenty grains of bromide of potassium, to be given every two or three hours according to the severity or frequency of the convulsions. I returned at 1 P. M. and was informed by the midwife that there had been several convulsions of great severity, and that the labor had considerably progressed. She had taken forty-five grains of chloral hydrate, and sixty of bromide of potassium; she had passed urine freely in the bed without giving notice.

Examination—discovered the os dilated about an inch and very rigid; the head presenting occiput to the left. I ruptured the membranes, discharging a large quantity of water, and then administered a mixture of chloroform and ether—1 to 3—and tried to dilate and apply forceps, but did not succeed, not having any one I could trust with the administration of chloroform, so I left the case for about an hour and a half, when I returned with Mr. Boree from the

Children's Hospital, who very kindly came to my assistance, and administered the anæsthetic, when I applied the forceps high up, and with the help of Mr. Boree delivered the head. The perineum did not suffer in the delivery of the head, the most careful examination could not discover the slightest rent. I congratulated myself on being so fortunate, and removed the forceps; and after a slight rest, during which I removed the cord from around the child's neck, I went on to deliver the body; but here I met with great difficulty, and became fairly tired out, when a strong expulsive pain came to my aid as I was making traction, and the delivery was completed; the placenta being immediately removed, before cutting the cord.

The child was large, weighing over eight pounds, and was dead; the mother, I am quite sure, did not weigh over ninety pounds.

The perineum was badly ruptured in the delivery of the shoulders.

There was very little blood lost during or after the labor; the uterus contracted up promptly. The blood that was discharged with the placenta was black.

I closed the wound in the perineum by two deep and two superficial sutures.

The convulsions were not checked by the delivery; they continued up to the time of the patient's death, which took place at 9 o'clock the next morning, twenty-four hours after the first convulsion, and seventeen hours after the uterus was emptied; she was not conscious after the first convulsion.

In considering this case, Mr. President, I think I have learned one or two things: In the first place I do not think that the puerperal state is always the prime factor in the causation of what is called "puerperal eclampsia." In this particular case, for instance, I believe the disposition to convulsive explosion existed prior to the puerperal condition, and that had this girl never become pregnant, some other accident or incident of life would have brought about a convulsive attack which might or might not have terminated fatally.

The midwife attending the case said that this was the first case of puerperal convulsions she had ever seen or heard of occurring in a colored woman, and I believe it is the first case I have heard of. From my own observation, without looking up the statistics on the subject, I will venture the statement that the colored race is equally with the white race subject to convulsive diseases. If this is not the case, and if the negro women are not as subject to puerperal convulsions as white women, I would account for this comparative exemption by the fact that they suffer less than the white women do in labor. Therefore, given a white and a colored woman both predisposed to convulsions, and both pregnant, the white woman would be most likely to be seized with so-called puerperal convulsions during the last months of pregnancy, and the colored woman should be most likely to escape.

The second point of interest that I wish to call attention to is that the convulsions did not seem to be directly dependent upon the uterine contractions. Simply introducing the finger into the vagina was resisted by the patient and disturbed her apparently very much, and the forcible dilatation of the os was still more painful; but in no case did it induce a convulsion.

The convulsions progressed with regularity from the beginning to the end without any regard apparently to the stage of labor or condition of the uterus, whether full or empty.

The mistake made in the treatment of this case was the haste to deliver. The labor could not be said to have fairly set in before twelve or one o'clock in the day, and within three hours from that time the delivery was effected. I feel satisfied that had chloral hydrate and bromide of potassium been given freely by the mouth, if the patient could swallow; by the rectum if she could not; with morphia hydermically, that she would not have died any sooner than she did, and might not have died so soon.

I will conclude with saying that I did not consider this a favorable case for bloodletting.

In the discusion which followed,

Dr. Kleinschmidt asked if any other means of cure but delivery had been tried.

Dr. Taylor replied that he had used chloral hydrate. He believed the rule is to deliver as soon as possible; but he thought he had been too hasty. In reply to Dr. Reyburn he said the pulse was weak. In answer to Dr. Johnson he said he had no opportunity of examining

the urine as it was passed involuntarily.

Dr. Fry said no criticism could be offered upon the action of Dr. Taylor in delivering early. If pressure on the kidneys has anything to do with these convulsions, early delivery is the course. He thought, though, that Dr. Taylor was open to criticism for not having done more to relieve the convulsions. He thought the chloral and bromide should have been pushed. He himself had more confidence in the hypodermic injections of morphia. Aconite and veratrum viride have been tried. He would also have used pilocarpin and hot applications in order to produce diaphoresis. He knew there was danger of producing serious disturbance with jaborandi. For not only is distressing salivation sometimes caused, but also a bronchorrhœa so great as almost "to drown the patient" in her own fluids. But no case that he had seen, died from jaborandi.

Dr. Taylor agreed with Dr. Fry as to the use of chloral and bromides. He had ordered them to be continued, but his directions were not followed. The condition of the patient contraindicated the use of pilocarpin. He was compelled to dilate the os forcibly, and to apply the forceps high up. The perineum was torn by the shoulder and not by the head.

Dr. Reyburn thought Dr. Taylor had acted properly in delivering early. He believed that unmarried women suffered more from convulsions on account of shame and their nervous condition. He did not think he would have bled in this case; but when the pulse was good he had obtained marvellous results from bleeding. In one case where the convulsions continued for twelve hours after delivery they ceased immediately upon the patients being bled to the extent of twenty-four ounces. He believed the convulsions were kept up by vascular pressure on the brain. He thought we bled too little, and that we would bleed more freely in the next twenty years. Morphia and pilocarpin should have been tried in this case.

Dr. W. W. Johnston thought the hypodermic use of morphia should have been tried. He had never seen it fail. He believed it valuable in uræmic convulsions of any kind. In a recent case of sclerosis of the kidney where convulsion followed convulsion, they ceased upon the hypodermatic use of morphia, and the patient is still living. He would keep his patients fully under morphia, hypodermically administered. He considered pilocarpin a dangerous remedy. In a recent case of scarlet fever where the child had a dry skin and intense fever with every secretion suspended, two enemata of jaborandi were given. If the child did not die of suffocation, at least the drug hastened its death. In such a case of hyperæmia, pilocarpin is a dangerous drug. In puerperal eclampsia, however, it often proves beneficial.

On motion the discussion was closed and the Society adjourned.

Editorial.

SUGGESTIONS UPON THE RELATION BETWEEN THE DIET AND GROWTH OF THE TUBERCLE BACILLI.—In his Croonian Lectures on the "Hygienic and Climatic Treatment of Pulmonary Phthisis," delivered at the Royal College of Physicians, last month, *Dr. Hermann Weber*, calls attention to a subject which has not been referred to hitherto in this connection, but which may be found hereafter of very great importance in connection with both the prophylaxis and therapeutics of this formidable disease. It is well known that the minute organisms which are known or supposed to be concerned in the production of disease, like the more highly developed, need certain kinds of food for their life and growth. In the case of the aspergillus niger it has been shown by researches of Dr. Duclaux that a liquid containing certain saccharine alkaline and mercurial ingredients may be prepared which will cause the spores of this fungus to develop so as to weigh 25 grammes. Now, by leaving out the potassium the result will be one gramme only, or 1-25 of what it was. If the phosphoric acid be omitted it will fall to 1-200, and if the ammonia to 1-150; if the zinc to 1-10. In other words the zinc which represents only 1-50000 weight of the nutritive fluid increases the crop of the plant by 700 times its own weight. It was also found that the addition of 1-1600000 of nitrate of silver checked the growth at once. Now we are perfectly justified in assuming that a similar relation exists between the tubercle bacillus and the constituents of the tissues, the blood and cells, especially the saline materials. What elements those are

which form the growth of this bacillus remains to be determined. If we could ascertain their nature and could limit the amount in which they enter into the blood and tissues without harm to ourselves by abstaining from food containing them, the result might be highly beneficial in that we would have the means of starving out the organism. The subject is enveloped in great difficulties, but it promises rich results, and should enlist the interest and labors of our best experimentalists. The study should include also an investigation of other agents capable of affecting the growth of the organism. In this connection the views of Drs. Salisbury and Cutter, with reference to systematic dieting, become of interest since they claim remarkable results in the treatment of consumption by a strict regulation of the diet, although they have not adduced any evidence, so far as we are aware, showing any influence upon the life history of the bacilli such as is above referred to.

Degeneration from City Life.—Mr. James Cantlee, F.R.S., in a lecture before the Parkes Museum of Hygiene of London recently, presented a startling picture of the unfavorable influence of life in that great centre of population upon its inhabitants. We cannot help thinking that he has very much overdrawn the picture, and that he has taken what is at best only of frequent occurrence among the lowest class of people as the prevalent condition of things. Yet he speaks very absolutely, and coming from so high an authority it is startling to reflect upon the wide range of application which his remarks may have, even reaching our American city population. The degenerating influences of city life—with its crowds, its dust, its vitiated atmosphere, its deprivation of sunshine and light and want of healthful out-door exercise—cannot certainly be exaggerated, and the most intelligent efforts of sanitarians are needed to deal with the problems connected with these sources of physical degeneration.

It is well nigh impossible, said Mr. Cantlee, to find a third, and absolutely impossible to find a fourth generation of pure Londoners—the progeny ceases partly from moral and partly from physical decline and inability of continuance. The pure Londoner of the third generation, which he has been able, after much search and inquiry, to get hold of, is a picture of physical decline, involving shortness of statue, narrow chest, deformity of jaws, miserable appearance, (squint prevailing), scrofulous diseases and small head. Pure Londoners are seldom to be found in work-houses, because they die young. The only notion a Londoner has of relaxation is a run to the country or the seaside on a bank holiday. He foretold evil to the townsfolk of to-day if measures were not taken to provide means of exercise in fresh air. It is a serious question whether the welfare of this country shall in the next generation be left to a race out of whom all enthusiasm and earnestness has passed.

The Annual Meeting of the American Medical Association.—The thirty-sixth annual meeting of the American Medical Association will convene on the 28th of April in the city of New Orleans. It has been many years since the Association has be held in that city, and the fact that the World's Exposition is now being held there lends additional importance and interest to this meeting. It is believed that the attendance will not only be very large, from the fact that the exposition will prove a source of attraction, but that the work presented to the Association will be of more than common value. The Association has grown each year into greater popularity and esteem with the profession, and its annual deliberations are being watched with greater interest than was the case only a few years ago. One of the most promising signs of the healthy growth of the Association is the fact that the leading minds in the profession are lending their aid and presence at its meetings, and are contributing more liberally to its scientific work. In this fact we think rests the future value of the Association. When the scientific work presented to the Association begins to show originality and careful preparation, its deliberations are sure to attract a wide-felt interest and to arouse a national professional pride. In former years the Association did not receive that support from the profession to which it was entitled. The papers presented at its annual meetings were generally tame and common-place productions, which fortunately were hidden away in the annual volume of Transactions, which was accessible to comparatively few readers. Since the in-

auguration of the Association's Journal some improvement has been manifested in the quality of the articles read at its meetings. The meeting at Washington last year was as much an improvement over its predecessors as the present meeting promises to be over that.

All physicians who can attend these annual meetings should consider it a duty to do so.

Cholera Precautions.—The probable appearance of Asiatic cholera in this country during the coming summer emphasizes the importance of taking steps in advance to prevent a rapid spread of this disease. That this subject has received proper consideration by various health boards we have no doubt, but it does not seem to us certain that the proper precautions are being taken by the health authorities of our own city and State. We are not informed whether our city is to be placed in the best possible sanitary condition at this time or whether the city authorities will await the advent of the disease and then prepare an attack. The latter policy is the one which has generally prevailed in this community. Since our city is in direct communication with foreign ports and has large commercial relations with the outside world, it would seem to be eminently proper to begin at once a system of defence against an enemy which may gain a foothold without a skirmish. Whilst, then, we may not fully realize our exposed situation, one of our distant sister States fully comprehends the necessity of a preparation in advance. The Illinois State Board of Health is determined not to be caught napping, either by cholera or any epidemic disease. In a circular recently issued by this Board, addressed to county clerks throughout the State, the request is made that the work of getting public institutions into good sanitary condition be completed as soon as possible. The Board urges that accumulations of filth and refuse be promptly removed; that defects in plumbing, drainage, and sewerage, disclosed during the winter be repaired; and that the effects of the occupancy of dormitories, workshops, wards, cells and other apartments be remedied by a thorough spring cleaning. The officers in charge of almhouses, jails, and all other public buildings under the control of the County Board are notified to commence this work at once.

The Board urges that especial attention should be given to the location and condition of privies and water-closets at these places, as also at court houses and elsewhere. It is suggested that vaults should be emptied before warm weather makes such work dangerous, and then be thoroughly disinfected with copperas. Suggestions are given relative to the location of vaults at proper distance from well, spring, pond, lake or running stream, and in the methods of ventilation and disinfection of the same.

The source of water-supply, and its storage and distribution, is considered a matter of great importance by the Board. A pure water-supply is considered of the first importance to health under all circumstances.

These numerous precautions the Board urges to be undertaken before warm weather sets in, not alone through fear of cholera, but in the interest of public health, and, consequently, of true economy. In other words, in the opinion of the Board, the true method of combatting cholera and of preserving the public health is to institute thorough sanitary measures in advance of the summer season. The proper time to clean our houses, privies, out-buildings, streets and alleys is during this and the next month.

We have every assurance if this work of thorough sanitation is done at once and thoroughly well, cholera will not gain a foothold here, and the health of our people will be good during the coming summer. It is to be hoped the "penny wise and pound foolish" policy will not prevail here this summer.

Miscellany.

Treatment of Bromidrosis of the Feet.—Dr. J. S. Stewart, in the *Edinburgh Med. Journal* for March, 1885, recommends as the most satisfactory treatment, to have the feet thoroughly washed in hot water, then steeped for a few minutes in a solution of permanganate of potash of the strength of from 4 to 6 grains in the ounce of water. The feet are then dried, not to be again wetted until complete exfoliation of the tanned cuticle has taken place.

Hebra's lead plaster ointment is then thickly spread on strips of cloth about one inch and a half broad, and the foot covered from the toes back over the heel as high as

the malleoli with these, arranged and applied like a scultetus bandage. Each toe should first be wrapped round with a strip of clean rag half an inch broad and thickly spread with the ointment. This dressing should be renewed every twelve hours with fresh rag and ointment, for a period varying from ten to sixteen days, according to the severity of the case and the thickness of the heel skin. In most cases the odor will be very much diminished by the end of the third day, and will not be perceptible by the ninth. The shedding of the skin takes place *pari passu* with the growth of the new cuticle, and may not be completed until the end of the third or even of the fourth week.—*Med. News.*

Potassium Iodide Rash Simulating Variola.—In a report made to the Health Office of the District of Columbia, for the year ending June 30, 1882, Dr. Llewellyn Eliot, of Washington, made a statement to the effect that many subjects are unable to take even the smallest quantity of potassium iodide without experiencing symptoms of an identical character to those of small-pox. This assertion was called in question at the time by many physicians of experience, and Dr. Eliot now reports the following case in its support: "On March 2, 1884, he was called to attend a recently married woman, ninteen years of age, suffering from hemoptysis. This was controlled by gallic and aromatic sulphuric acids, and two days later, there being some pleuritic pains on the left side, a mixture was ordered containing sixteen grains of iodide of potassium in an ounce of mucilage of gum acacia, of which a teaspoonful was to be taken every two hours. This was at one o'clock in the afternoon. At six she complained of pains in the lower jaw, and by midnight had the coryza, injected conjunctivæ, puffiness of the face, severe headache, aching of the body, especially in the back, soreness of the throat, and the appearance of red spots over the face. The red spots increased in prominence in a few hours, just as occurs in small-pox. Careful inquiries made the following morning failed to show exposure to variola, and the iodide was accordingly discontinued, and one-fourth grain sulphate of morphine given, together with hot whiskey. At nine o'clock that evening the pains had ceased, and the eruption was fading, and two days later had entirely disappeared. The symptoms of iodism followed the second dose, when but four grains had been taken."—*Med. Record.*

Novel Remedies in Dysmenorrhœa and Menorrhagia.—Huchard, of Paris, employed for several months the virbunum prunifolium, not only against the pains of dysmenorrhœa, as recommend by Dr. Herr, of Philadelphia, but also as a general tonic of the nervous system. This action, Huchard thinks, is due to its containing considerable quantities of valerianic acid, combined with a bitter principle and tannic acid. Viburnum is used in doses of (1-6 grm.) 1 to 3 fluid drachms of the fluid extract or the tincture, and replaces advantageously as an anti-spasmodic the preparations of valerian. Huchard prefers the use of hydrastis canadensis to that of ergot, for uterine irregularities. The drug has, besides, as pointed out by Schatz, of Rostock, decided anti-catarrhal properties. This double action of hydrastis is due to the presence of two alkaloids, hydrastine and berberine. Its value in all catarrhal affections of the alimentary tract, the bladder, the urethra and uterus, is considered as firmly established. In the menstrual disorders it is to be given in doses of 40–50 drops of the fluid extract daily during and preceding the week of menstruation. In dysmenorrhœa and menorrhagia Huchard has used hydrastis and viburnum conjointly, with gratifying results, in doses of 10 drops every two hours.—*Journal de Médecine.*

Purulent Ophthalmia in Infants.—Mr. Cowell's paper on this subject before the Harveian Society of London (Feb. 5, 1885), had for its special aim to show that the large amount of blindness due to this disease could be avoided if (1) the people could be instructed as to its dangers, and if (2) medical men universally recognized the futility of only temporizing measures. This object could best be attained by unremittingly, and by every means, endeavoring to diffuse a knowledge of the disease and of its dangers, through the dispensaries, the clubs, the lying-in institutions, and the visitors of the sick poor. Prophylaxis was the next important duty. In respect of treatment, the first essential was no time should be lost. The indications were (1) to remove the conjunctival discharge as rap-

idly as it formed, (2) to relieve tension, (3) to watch and treat the complications. In addition to the usual rules of treatment, Mr. Cowell recommended that the affected eyes should be cleansed every quarter of an hour with weak antiseptic lotion, and the conjunctivæ painted with solution of nitrate of silver (four to six grains to the ounce) daily in severe cases, twice or thrice a week in mild ones, the free solution being washed away with antiseptic lotion. When there was much discharge, alum or boracic acid might be added to the lotion. The *cul-de-sac* under the upper eyelid required careful washing out. The ablutions might be less frequent during sleep, and gradually diminished as the discharge lessened. Where severe chemosis occurred, scarification was necesssary.

Mr. Juler inquired whether severe cases could be diagnosed early from milder ones. He quoted some investigations of Dr. Widmark (*Revue Generale d' Ophthalmologie*, Sept., 1884), in which twenty-two cases of purulent conjunctivitis had been examined (four adults and eighteen infants). Bacteria, described as gonococci, were found in the majority in the fluid in the pus-cells, and in the epithelial cells. In the adults he discovered gonococci in the urethal secretion; and in the infantile cases, in the urethral discharge of the mother. The gonococcus was absent in six of the infantile cases, which ran a mild course. The antiseptic lotion used for the ablutions should be weak (0.5 per cent. carbolic or boracic acid). The conjunctivæ, if severely swollen, should be freely scarified; and, if eversion of the upper lid were impossible, the outer canthus should be divided.

Mr. H. Power said that, when due to gonorrhœa, cases were likely to do badly unless they received skilled treatment early. On a wide average, cases, if seen in the first week, would recover; if in the second week, they would run a dangerous course; if in the third week, they were hopeless.—*Med. and Surg. Rep.*

Quinine and some of its Congeners as Parturients.—1. Quinine or quinetum in doses from four grains upwards, in powder, will start pains afresh in 20 to 30 minutes. Repeated at intervals of half an hour or an hour, it will maintain them strong. 2. It produces no headache—hardly ever a trace of the cinchonism caused by similar doses under other circumstances—nor sickness, the bitter taste being the only disagreeable circumstance connected with it. 3. The pains it produces are not continuous, like those of ergot, but intermittent like those produced by normal labor, and evidently not the result of a special stimulus exerted over the uterus only, but of a tonic effect exerted over the whole economy. The patient often feels stronger. 4. The action produced when ergot is given alone in cases where the patient has been exhausted seems often to be spent in the delivery of the child, leaving the uterus in a state of exhaustion, unable to contract upon and expel the placenta, allowing hemorrhage and necessitating extraction. Such is not the case when quinine is properly used, either alone or before the ergot. 5. It can be used where ergot is absolutely contraindicated, with perfect safety to both mother and child. In one case, five or six hours intervened between the giving of the first dose and the onset of the pains and the delivery of the child, yet all was right. Except in one case. I do not remember a child having been born alive when more than two hours elapsed between the administration of ergot and delivery.

In short, we have in this agent effective means of delivery with tedious uncomplicated labor, *tuto, cito et jucunde.* The good is not confined to the delivery of the child, though that is the point with which I wish to deal; but I believe I have also noticed the antipyretic and antiseptic influence of quinine in the more satisfactory recoveries than I used to have. I can confidently recommend it as an invaluable addition to our armamentarium.—*Dr. Andrew Mullan, M. A., M. D., in Brit. Med. Jr.*, Feb. 28.

The Abortive Treatment of Diphtheria.—In a brief communication to the *Berliner Klin. Wochenschrift* for Jan. 25, Dr. Coestes, of Biebrich, adds his testimony as regards the efficacy of the abortive treatment of diphtheria by calomel. He has recently treated five cases, including his own, by the administration of 15 grains of calomel, generally in three doses, closely repeated. Only one terminated fatally, and in that, the trachea was so much obstructed when he was called, that tracheotomy seemed inevitable. Succeeding the administration of calomel, however, with

frictions of mercurial ointment and inhalations, the dyspnœa grew much less. Ultimately, however, the operation was performed, and the child died on the seventeenth day. The remaining cases all recovered, and Dr. Coestes justly says no one can take it amiss, if he, in consequence, has had his faith in the abortive treatment strengthened.—*Med. News.*

A Medical Student aged Seventy-four.—Our Berlin correspondent writes; It is not often that one hears of a student of the age of seventy-four taking a degree at a university. The "bernoostes haupt" is sometimes to be seen at German univer sities, but he is generally a man who has spent his last years in idleness. The Nestor of the Berlin students to whom I now refer has been studying at Berlin since 1881, and has just taken a degree as Doctor of Medicine. The professors addressed him as "worthy colleague," the students as "papakin." In 1833 he was matriculated at Berlin, and studied theology till 1837 and and spent his time from then till 1881 as a missionary in South Africa. It had been his wish all his life to study medicine, but pecuniary difficulties stood in his way. Now that he has passed his examination, having worked with all the zeal of a young student, he is going to return to Africa, where he will practice medicine.—*Brit. Med. Jour.*, Mar. 7.

Cocaine and the Opium Habit.—The writer has for many years had a correspondence, taking up a good deal of time, in relation to "cures" for the opium habit, and lately this correspondence has increased, and refers to the use of coca or cocaine as this long sought "cure." These letters are generally from physicians, but not unfrequently from subjects of the habit or their friends, and the old, old story of having tried the various advertised and vaunted "cures," with the result of finding either that they did no good, or that the cures were themselves some preparations of opium or morphine, the net result being only money in the pockets of the quacks. Cases which appear to be "cured" by the quacks, and there are such, —must in reality recover only through the courage and the perseverance of the subjects themselves.

Many physicians, as well as the subjects of the habit and their friends, lose sight of the circumstance that this habit is a vice, like the alcohol habit, and not a bodily disease to be dosed,—and this vice absolutely beyond the scope and reach of medication. Almost as well might they expect to cure lying or stealing by doses of drugs. The writer, in common with many others, has known many cases of this habit, and some recoveries from it, but never knew a single recovery that was not due to the moral courage of the subject of the habit. Nowhere are the lines of Cowper more applicable:

> "Habits are soon assumed; but when we strive
> To strip them, 'tis being flayed alive.

And it is this being "flayed alive" that many subjects of this vice refuse to summon courage enough to submit to. Many do this in every stage of the habit, and all might do it if they would, and "cures" by drugs are only sought through some degree of moral degradation or cowardice, which gives an alluring, but false idea of the word "cure."

Subjects who will morally train themselves up to take hold of themselves, can break the habit either abruptly or gradually, and will recover from its dominion and its effects. Those who will not do this, doom themselves to certain moral and physical destruction. With sufficient courage no help is needed; without it all help is in vain. Restraint either in or out of inebriate asylums or hospitals may aid effectively in breaking the habit, if a good degree of moral courage be summoned as a basis for action; but without moral courage, restraint must be perpetual to be of any use.

When a subject has courage enough, and is in earnest to begin a vigorous campaign against his habit, he soon reaches a stage analogous to the delirium tremens of the alcohol habit, and here the wise and careful physician may be needed, and medication is often available, the more effective of the nervous stimulants and restoratives being the best agents. To tide over the period of greatest suffering and to relieve it somewhat, whether it be for a day or two, or for a week or two, is quite within the reach of the materia medica, and different agents will be more or less effective in different cases. Alcohol, cannabis indica, coffee, tea, etc., are all available, and in this class coca will take a place, but probably not as a prominent agent. But the

salts of the alkaloid cocaine are not likely to be of any use.—*Ephemeris.*

Platt's Chlorides.—The *N. Y. Med. Journ.*, in speaking of this valuable disinfectant, says:—"In a recent conversation, Professor Alfred L. Loomis remarked that chloride of zinc had maintained its long-established reputation as a disinfectant, as was shown by Miguel's classification. Sulphurous acid and chlorine were powerful germicides, beyond question, but their every-day use was impracticable, and the bichloride of mercury, although it might be the most potent of all the agents that were chiefly talked about, was hardly to be considered safe for domestic use. But the preparation known as "Platt's Chlorides" (a solution of the chlorides of zinc, lead, calcium, and aluminium), which he had made use of freely for the past five years, both in his own house and among his patients, he considered as by far the best for all the sanitary requirements of the household."

Transmissibility of Tuberculosis by Vaccine-Lymph.—Since Jenner's discovery the question of the transmissibility of tuberculosis by vaccine lymph has been much discussed and differently interpreted. The researches of Villemin and Koch, which have furnished good reason for believing that tuberculosis is virulent render the question still more important. In 1881, M. Toussaint, in a note communicated to the Académie des Sciences, stated that he vaccinated a phthisical cow from a healthy child; he afterwards inoculated a pig and a rabbit from the vaccine pustules of the phthisical cow, and both animals were attacked with tuberculosis. Koch's bacillus was not found in the lymph. M. Strauss has repeated these experiments. In the space of eighteen months five phthisical patients were revaccinated. Ehrlich's process failed to revive bacilli in the vaccine lymph of these patients. Inoculations from the vaccine lymph of phthisical patients were effected in the anterior chamber of the eye of rabbits but they remained exempt from tuberculosis; a few days after the operation the eyes were completely normal. The necropsy was made a few days subsequently but there was not the slightest indication of tuberculosis. M. Josseren, a pupil of M. Chauveau, made the same experiments as M. Strauss; they were equally negative in result and indicate that tuberculosis is not transmissible; thus twenty-four facts oppose one furnished by M. Toussaint.—*Paris Correspondent of Brit. Med. Journal*, Feb. 28th.

Medical Items.

The Royal Medical and Chirurgical Society of London held its annual meeting on March 2, and a very satisfactory balance-sheet was presented. The annual report showed a larger number of Fellows than in any previous year, namely, 741, and a larger number of attendances at the meetings of the Society. A larger proportion also of those who had attended had taken part in the discussion, namely, 145 out of 632. The library also had increased by 520 volumes, and 3,421 books had been lent during the year.—*British Medical Medical Journal*, March 7, 1885.

The seventeenth annual meeting of the Texas State Medical Association will be held at Houston beginning on Sunday, April 21.

It is well to make it a rule in all cases of abdominal disease, to submit the patient to a thorough examination as to diseases of the other organs before deciding upon any operation. It is especially important that the urine should be carefully examined, more than once, and the condition of the heart and lungs be investigated.—*Dr. J. B. Hunter in N. Y. Med. Journ.*, April 5.

The American Surgical Association will hold its next annual session in the Army Medical Museum, Washington, D. C., on April 21st, 22nd, 23rd and 24th.

A novel, entitled "Charley Kingston's Aunt," has been recently written by Sir Henry Thompson.

Dr. Jas. L. Little, the well-known surgeon of New York city, died recently at the age of 49. He held the chair of clinical and operative surgery in the N. Y. Post-Graduate Medical School and also the chair of surgery in the University of Vermont.

The next annual meeting of the Association of American Medical Editors will be held in New Orleans on the evening before the day of meeting of the American Medical Association.

A solution of sulphate of hydrastine, two grains to the ounce of distilled water, is said to be an excellent wash for inflamed and granulated lids. It is known as "Golden Eye-Water."

Mr. Arthur Thomson, M. D., Edin., M. R.C.S., Eng., at present Junior Demonstrator of Anatomy in Edinburgh University, has been appointed Lecturer on Anatomy in the University of Oxford.

The *N. Y. Med. Journ.* says that the Jefferson Medical College, of Phila., at its recent annual commencement, conferred the honorary degree of LL.D. upon Dr. Austin Flint, Jr., of New York.

According to a writer in the *American Journal of Obstetrics*, Michaelis, the Professor of Obstetrics at the University of Kiel, was a martyr to the doctrine of the infection of puerperal fever being carried from one patient to another. A near relative whom he had attended in confinement at a time while he was much occupied with autopsies on patients dead of puerperal fever, died of the disease, and the accoucheur, recognizing, in the light of the new investigations of Semmelweiss, that he had himself carried her the infection, laid himself on a railroad track before a train and was crushed to death.—*Boston Med. and Surg. Jour.*

Dr. Burdon-Sanderson suggests that the leading symptoms of rabies be printed on the back of dog licenses as a means of preventing hydrophobia. If the first cases were recognized in their earliest stages it would be comparatively easy to stamp out a commencing epidemic.

The Medical Society of North Carolina will hold its next annual meeting in Durham, on Tuesday, Wednesday and Thursday, the 19th, 20th and 21st of May. The Board of Medical Examiners will convene at the same place on the 18th.

Twenty-four medical colleges have been born in Ohio. Ten died in early infancy, while ten remain to vex the anxious reformer.—*Detroit Lancet.*

The next meeting of the Indiana State Medical Society will be held at Indianapolis on Tuesday, May 12th.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S Army, from April 7, 1885, to April 13, 1885.

Brown, Harvey E., Maj. and Surg. Leave of absence extended two months.

Beart, Victor, Capt. and Asst. Surg. Leave of absence extended six months on surgeon's certificate of disability.

Capt. Stevens G. Cowdrey. From Dept. East to Dept. Mo.

Capt. Augustus A. DeLoffre, Asst. Surg. From Dept. East to Dept. Dakota.

Capt. Louis W. Crampton, Asst. Surg. From Dept. East to Dept. Platte.

Capt. George H. Torney, Asst. Surg. From Dept. Mo. to Dept. East.

1st Lt. William H. Arthur, Asst. Surg. From Dept. Platte to Dept. East.

1st Lt. M. C. Wyeth, Asst. Surg. From Dept. Dakota to Dept. East.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service for the week ending April 11, 1885.

Bailhache, P. H., Surgeon. Chairman of Board for physical examination of candidates for appointment as Assistant Engineers, Revenue Marine Service. April 6, 1885.

Vansant, John, Surgeon. Chairman of Board for physical examination of officers of the Revenue Marine Service. April 11, 1885.

Purviance, George, Surgeon. Granted leave of absence for one week. April 6, 1885.

Stoner, G. W., Surg. Member of Board for physical examination of candidates for appointment as Assistant Engineers, Revenue Marine Service. April 9, 1885.

Godfrey, John, Surgeon. To represent Service at annual meeting of American Medical Association. April 11, 1885.

Goldsborough, C. B., Passed Asst. Surgeon. To proceed to Pascagoula, Miss., as inspector. April 8, 1885.

Carter, R. H., Passed Asst. Surgeon. Member of Board for physical examination of officers of the Revenue Marine Service. April 11, 1885.

Original Articles.

FACTS SERVING TO PROVE THE CONTAGIOUSNESS OF TUBERCULOSIS; WITH RESULTS OF EXPERIMENTS WITH GERM TRAPS USED IN DETECTING TUBERCLE-BACILLI IN THE AIR OF PLACES OF PUBLIC RESORT, AND A DESCRIPTION OF APPARATUS.*

BY W. H. WEBB, M. D., OF PHILA.

(*Continued from page* 475.)

It has been satisfactorily demonstrated that tuberculosis may be caused by inoculation in the human subject. Lænnec, whilst examining a vertebra containing tubercle, slightly wounded one of his fingers with the saw blade. In the site of this wound a small, rounded tumor subsequentty appeared, which, upon investigation, exhibited all the physical characters of tubercle. It was destroyed by the application of an escharotic, and no bad effects resulted from it.*

Another instance was that a of fisherman free from tuberculosis, but suffering from gangrene of the toe, who was purposely inoculated. Thirty-seven days after the experiment he died, and the autopsy revealed a tuberculous deposit in the lungs and liver.†

But the most satisfactory evidence of the effects of inoculation of tubercle is that presented in the case recorded by Dr. E. A. Tscherning‡. The subject, employed as cook in the family of Prof. H., was a perfectly healthy woman, about twenty-four years of age, with a history unexceptionally free from any hereditary taint of scrofulous or tuberculous affections. After a short illness the Professor died of phthisis. The cook unfortunately broke the glass sputum-cup used by her employer, and a spicula from it punctured one of her fingers. Fourteen days afterward there appeared at this point what seemed to be a felon. This was treated at Prof. Studgaard's clinic, and at the end of a few weeks the finger was much better; a little nodule, however, about half as large as a pea, was found to exist in the subcutaneous connective tissue, which after awhile became tender and œdematous. This was now cut out, and the wound healed readily. About three months from the time of the accident, Prof. Studgaard found that the sheath of the tendon was thickened, and two cubital and two axillary glands were enlarged. He disarticulated the middle finger, and the tendon, with its thickened sheath, as well as the enlarged glands at the elbow and axilla, were dissected away. Upon examination, the sheath of the tendon was found to be filled with pale granulations. Sections of the sheath and of the extirpated glands were subsequently subjected to microscopic investigation, and numerous tubercle-bacilli found in them, which positively established the peculiar character of the affection.

Dr. Tscherning has observed upwards of thirty cases of localized tuberculosis, and in each instance the microscopical appearances were the same as in this case.

Many eminent men, by their constant attendance upon the phthical and by their close and frequent study of the post-mortem condition of their cases, have been made victims to the disease themselves. Among those who have met death in this way may be mentioned Bayle, Lænnec, Delaburg, Dance, Young-Thomas, and many other names could be added.

Much stress has been laid upon heredity as being one of the chief causes of the vast mortality from this disease. It is my belief that phthisis is never transmitted from parent to child; it is simply a predisposition that is inherited. By predisposition I mean a greatly lessened power of resistance in the tissues, especially in the lymphatic system. If tuberculosis was inherited we might expect to find some indications of this in the fœtus, but the observations of Guizot,* Gluge,† Heller,‡ and Virchow‖ have shown that this is not the case. In 1300 fœtuses examined by Heller there were no evidences of a tuberculous taint in any one of them, notwithstanding the fact that in one instance the patient died of phthisis with the fœtus in utero. Virchow, with his experience of more than fifty years, says: "He had not seen a single case of direct transfer in the fœtus." This also holds true in regard to the offspring of ani-

---

* Diseases of the Chest. Translated by J. Forbes, M. D. London, 1834, p. 305.
† Gazette Med., 1872, p. 192. Quoted in Biennial Retrospect of Med. and Surg., 1871-72, p. 38.
‡ Hospitals-Tidende, Copenhagen. Dec. 17th, 1884.

* Quoted by Dr. Durant. Trans. of the N. Y. Med. Soc., 1878, p. 174.
† Ibid.
‡ Medical News, Phila., 1884, p. 302.
‖ Ibid.

mals which have been under observation while suffering from tuberculosis; there is no instance on record in which they have exhibited a trace of the disease.*

The presence of the disease in infants is undoubtedly due to the bacillus, or its spores, contained in the milk of the phthisical mother, or in the air it is constantly obliged to breathe.† In other words, the disease is not transmitted, but it is acquired. I have elsewhere shown the fallacy of the hereditary transmission of the disease.‡

There are but few insurance companies that will accept as a risk any one whose family history is not clear of tuberculosis; hence it would seem that such careful exclusion would remove all questions of hereditary transmission in those losses which they may sustain by death from phthisis. One of the most conscientious companies in this respect is The Mutual Life Insurance Company, of New York. It is especially careful in excluding such risks, and will not only refuse to accept an applicant who has a phthisical history, however remote, but will not regard an application in which there is the least evidence of a predisposition to the disease, no matter what the age of the applicant may be. Notwithstanding the exercise of an unusual amount of vigilance, they are nevertheless obliged to declare that "Consumption has been the occasion of more deaths than any other disease, giving a per centage of $17\frac{11}{100}$ of the total mortality; while deaths recorded under other headings, but properly belonging to this, would swell the number to 20 per cent."§ Here, then, is a freedom from an hereditary taint as far as rigid examinations are capable of determining it. Under such circumstances the rate of mortality is surprising, to those, at least, who have faith in the hereditary transmission of the disease. A few years previous to that in which this report was made, the death rate from consumption in the adult male population of New York City was $30\frac{17}{100}$ per cent.. This is but little over 13 per cent. of the deaths among those who were considered especially exempt from the disease.

It would be impossible to enumerate the so-called causes of tuberculosis. The disease has been attributed to every imaginable influence which could occasion a morbid condition of the system. This error is readily accounted for when it is understood that any influence which will bring about a lowered vitality of the body will induce a predisposition to the disease, which is established by the presence of the bacillus tuberculosis.

Age.—In looking over "health reports" and other statistics I have been surprised at finding records relating to the time of life when tuberculosis is most prevalent, which are entirely at variance with the ideas entertained by many practitioners. It is very generally believed that at the age of puberty, especially in those supposed to possess hereditary taint, phthisis is most apt to manifest itself, and that the liability to contract the disease is lessened with advancing years. It seems, however, that this is not the case, for in early childhood and at puberty the mortality is less than at any other period of life. There is reason for believing that the best way to determine the time of life at which the disease is most fatal is to compare the death rate occasioned by it at certain periods of life with the number of living persons at the same age. This has been done by several reliable persons, including Dr. Edgar Holden,* and I will read to you an interesting table prepared by A. Wuerzberg, the librarian of the Imperial Health Office at Berlin, Prussia.† This table is as follows:

Of 10,000 individuals aged	0– 1	year	there die annually of consumption			$25\frac{15}{100}$
"	"	" 1– 2	"	"	"	$20\frac{41}{100}$
"	"	" 5–10	"	"	"	$4\frac{66}{100}$
"	"	" 15–20	"	"	"	$18\frac{37}{100}$
"	"	" 20–25	"	"	"	$30\frac{24}{100}$
"	"	" 25–30	"	"	"	$36\frac{73}{100}$
"	"	" 30–40	"	"	"	$41\frac{12}{100}$
"	"	" 50–60	"	"	"	$67\frac{94}{100}$
"	"	" 60–70	"	"	"	$93\frac{18}{100}$
"	"	" 70–80	"	"	"	$61\frac{78}{100}$
"	"	over 80	"	"	"	$25\frac{80}{100}$

*Practitioner, London, Vol. xxx, 1883, p. 318.
†British Med. Jour., 1879, Vol. xi, p. 619.
‡"Reasons for Believing in the Contagiousness of Phthisis." Read before the Philadelphia County Medical Society, June 11, 1884.
§Preliminary Report of the Mortality Experience of the Mutual Life Insurance Company, of New York. New York, 1875, p. 12.
*The Medical Record, New York, July 12, 1884.
†American Jour. of the Med. Sciences, July, 1884, p. 192.

This table goes to show that at the two extremes of life, where vitality is at the lowest, thus lessening the power of resistance, the disease is most fatal.

It must not be forgotten that among the many causes which lead to a predisposition to tuberculosis, conditions of mental depression play an active part. Bad habits or immoral conduct, which lead to bitter regrets; or domestic infelicity, occasioning long continued fret and worry, will produce a depression of this character more or less marked. A case recently came under my notice in which the patient's health was first affected by the unfortunate conditions of his domestic affairs; they were the occasion of continued anxiety and worriment for several years, and finally brought him into a condition of nervous exhaustion. This was soon followed by the signs of phthisis, and he died about six months afterwards. In this case the predisposition was certainly due to a lowered vitality, induced by long-continued mental depression, aided somewhat by the patient's occupation, which was that of a bookkeeper. There was no hereditary tendency to the disease, and had he been more fortunate in his domestic relations he might still be living.

The following interesting cases, which I have personally investigated, will go to support some of the assertions I have made in my paper:—

Case 1.—J. E., an invalid, was married; twelve months afterwards his wife gave birth to a child, and in the following month the father died of phthisis. At the age of five months the child died of marasmus, and in sixteen months after her accouchement the wife died of phthisis. She was of a healthy and long-lived family, but had occupied the same room with her husband during his illness.

Case 2.—S. Y. was a healthy young man, who married a lady that was physically below par. About a year after marriage she gave birth to a child, and from this period onward she declined in health and ultimately died of phthisis five years afterwards. Eighteen months prior to her death her husband exhibited symptoms of tubercular laryngitis, and died of consumption four weeks before his wife. In this case I ascertained that the wife had come from a tuberculous family (her parents and five sisters having died from the disease), while in the husband's family there was not a trace of tuberculosis, his family living far beyond the allotted threescore and ten, and his brothers and sisters in the full enjoyment of health. This gentleman, who was greatly devoted to his wife, had been constant in his attendance upon her and had slept in the same room.

Case 3.—I. R., a young man, aged 27 years, of very temperate and regular habits, who presented no family history of tuberculosis, and whose constitution and general health were excellent, married a young lady of delicate health, in whose family consumption had caused the death of father, mother and three sisters. The occupation of the young man was that of ticket agent in a railroad office. About three and a half years after his marriage he became ill, and a year after the commencement of his illness died of phthisis. Two years and a half subsequent to his death his wife died of the same disease.

In the first case narrated to you the healthy, robust bride certainly contracted the disease from her husband. In the second case the young man, with an excellent family history and in good health at the time of his marriage, not only contracted the disease from his phthisical wife, but died of it four weeks before she did. In the third case we have a healthy and vigorous young man, with an excellent family history, marrying a phthisical girl from a phthisical family, and what is the result? Through his close companionship with his consumptive wife he contracts the disease which occasions his death two and half years before his wife succumbs to the malady.

I might add to this list a number of similar cases, were it necessary to do so, for I have the notes of many which prove conclusively the contagiousness of phthisis. Indeed, any one can lay his hands upon recorded cases without number which would convert even the most skeptical to this belief.

No one, not even the non-contagionists, can declare that the cases I have narrated are simply "coincidences." The experience of medical men, especially of those who are engaged in the treatment of lung disorders, must be similar to my own, and I cannot see how there can be a question in their minds in regard io the contagiousness of phthisis.

[*To be Continued.*]

A RUNNING COMMENTARY ON THE GRANT CASE.

By Richard McSherry, M. D., of Baltimore.

The intimate pathology of cancer, notwithstanding the immense study bestowed upon it by the ablest investigators, macroscopic and microscopic, is still enveloped in mystery.

The microscopist who examined, *more experto*, the specimens from General Grant's throat and found them to be carcinomatous, says, frankly enough, that he did not judge from the microscopic revelations alone, but also from all the facts he could obtain of the previous history of the parts furnishing the specimens. By collating all the facts only could he pronounce the disease confidently to be cancerous.

The ordinary or extraordinary clinical observations are not sufficient, *per se*, neither are the microscopic findings—but both together give a very near approach to certainty. The microscope tends to confirm the grosser observations. Virchow once remarked that from long comparative observation he could distinguish the nature of a tumor from macroscopic examinations, with the assurance that the microscope would but confirm his pronounced opinion.

Before the microscope was brought into daily use as the final appeal in all dubious morbid growths, (though it is not now, nor is ever likely to be an infallible criterion), good clinical observers were about as accurate for all practical purposes as are the searchers into pathological mysteries of the day.

In Sir Benjamin Brodie's clinical lecture on *Diseases of the Tongue*, published some forty or fifty years ago, there will probably be found as much *knowledge*, if not as much *learning*, as in any thing since given to the medical world. It may be mentioned, by the way too, that Sir Benjamin made a class of half-malignant tumors, that is of growths thoroughly malignant so far as their local agency goes when not arrested, but which when entirely removed, admit of the patient's perfect recovery.

The best practical facts in the treatment of cancer since the days of this eminent surgeon, were brought to bear in General Grant's case in the use of cocaine and the hypodermic injection of morphia. There can be little doubt that these two agencies prolonged the General's life by tiding him over sufferings, which but for them would have been too great for human endurance. Suffering abated, it often happens that malignant, semi-malignant or other destructive growths or deposits, as tubercle, become so favorably modified that the patient may be respited for weeks, months, or even years.

If this should be the case with General Grant, it by no means follows, as some of the critics suggest, that his medical attendants made mistakes in diagnosis or treatment, but rather that they did the best for him practicable under the circumstances.

Withal what a satisfaction it ought to be to the doctors in general and to the world at large to find that there are so many critics, of the daily press especially, whose knowledge is not less wide than the Atlantic ocean, nor less deep nor clear than a mud-puddle, who are as willing and ready to instruct doctors in medicine, as soldiers in war, clergymen in theology, or presidents and cabinet ministers in statesmanship. It is not only bad books at this day that are constantly assailed by worse critics, but everything, good, bad and indifferent has to endure the same old infliction.

Society Reports

CLINICAL SOCIETY OF MARYLAND

STATED MEETING HELD APRIL 3, 1885.

(*Specially Reported for the Maryland Medical Journal.*)

The Society was called to order by the President, Dr. B. B. Browne, at 8.40 P. M., Dr. Jos. T. Smith, Secretary.

STRICTURE OF THE RECTUM.

According to resolution, the discussion of the paper of *Dr. O. J. Coskery*, read at a previous meeting, was called for.

See Md. Med. Jour. March 21st, p. 391.

Dr. O. J. Coskery said he had made two points in his paper; first was it a case of cancer involving the rectum, and second was it located in the rectum from an hereditary weakness of that part of the organism. He noted the following in his own family: His grandfather, two uncles and an aunt died from stoppages of the bowels; no hernia; they died from constipation; this would seem to point to a special weakness of the intestinal canal in these persons. In only one case was a necropsy held, but no trouble that could account for the death was found beyond the fact of constipation.

Dr. N. G. Keirle thought literature very barren on this subject. That diseases such as syphilis are hereditary is well-known; but in addition other tendencies may be inherited; thus one may inherit a tendency to the proliferation of connective tissue, or a suppurative tendency, or even stricture of the urethra might be shown to be hereditary. Upon one occasion he had made an autopsy in the case of a man, 60 years of age, who for some time had suffered from constipation, and at the point of juncture of the transverse with the descending colon a stricture was found which would only admit the finger, behind which the intestine was much enlarged; the stricture was innocent in its nature. Take this in one with a a connective tissue diathesis; first would come the collection of feces; irritation would be set up with a proliferation of connective tissues, and so the stricture would result. It is not improbable that many of his family may have had the same trouble.

Dr. J. N. Mackenzie then read notes from a paper entitled

RHINITIS SYMPATHETICA VEL REFLEXA.

(See Md. Med. Journ., April 11th, 453).

In reply to a question from *Dr. Meierhof*, Dr. Mackenzie said he thought the eye trouble likely due to reflex irritation, and that the eye trouble was improved without any treatment used with the eye itself.

Dr. H. Woods read the

REPORT OF A CASE OF RAPIDLY RECURRING GROWTH IN THE EXTERNAL AUDITORY MEATUS.

(See Md. Med. Journ., April 11th, 456).

Dr. S. Theobald thought there must have been serious trouble in the mastoid cells and that the polypus was secondary. If it came from the mucous membrane it should not have assumed a dermoid character.

Dr. W. F. Coleman said we find such cases on record, but they are rare; so far as described he thought the growth an osteosarcoma. He then noted the following: A man, aged 40, came to him; he had a discharge from the middle ear; pain severe for one year; tympanic membrane perforated; treatment did not relieve the pain. As far as known the mastoid was not involved. The patient passed from his care and went to N. Y.; a malignant disease there showed itself. He thought the recurrence of the trouble and the long-continued pain would show the disease to have been malignant. In reply to a question from Dr. Theobald as to whether simple inflammation of the mastoid cells would not give rise to pain without the trouble being necessarily malignant, Dr. Coleman said pain lasting for a year and the fact of the tumor reappearing would indicate malignancy.

Dr. N. G. Keirle said all the pathologist can do with a given tissue is to pronounce upon its nature. A tissue is disposed to produce its kind, and the rapid reappearance of a polyp does not show its malignancy. Chronic inflammation would give rise to hyperplasia.

Dr.. H. Woods agreed with Dr. Keirle. He thought the polyp one of the skin. The persistent pain without purulent discharges would seem to indicate that inflammation of the mastoid cells did not exist. If due to involvement of cells of the middle ear bone conduction ought to have existed.

Dr. J. G. Wiltshire said all primary malignant troubles of the auricle are epithelioma, according to Holmes.

Dr. S. Theobald thought the chronic inflammation would not necessarily imply the discharge of pus.

Dr. W. F. Coleman exhibited specimen of a growth thought to be round cell sarcoma, which he assisted in removing from just above the ankle, in a man aged 35 years.

Dr. W. B. Platt exhibited a specimen of the

LARYNX, TRACHEA AND BRONCHIAL TUBES FROM A PATIENT UPON WHOM HE HAD PERFORMED TRACHEOTOMY AT BAYVIEW.

The patient was a child suffering from croup. The trachea was opened, but not before much hemorrhage had occurred, which was speedily checked when the tube was opened. The patient died subsequently, and the autopsy showed a saddle-shaped deposit at bifurcation of the trachea plugging up both bronchial tubes.

Dr. R. Winslow said bleeding was common in such cases, but will cease when trachea is opened; still we are taught not to open trachea until the bleeding c ases. The way to obviate the difficulty is to first turn the child over on abdomen, then open the trachea. He thought it difficult often-

times to tell true from spasmodic croup and noted the case of a child in whom the dyspnœa was extreme, but the patient recovered under a full dose of ipecac.

Dr. R. W. Johnson called attention to the latest treatment of diphtheria, which is said to have met with much success, namely, the digestion of the membrane in the throat with tripsine. Thought ether would clear up the diagnosis, as between true and spasmodic croup.

In reply to Dr. Johnson, Dr. Platt said he had removed the tube because recently good results had been obtained from an early removal of the tube, even as soon as the third day; in some cases, indeed, the tube had not been used at all. Better results have been claimed for this mode of treatment, as the tube must act as a foreign body.

Dr. I. E. Atkinson thought the specimen seemed to show rather a catarrhal inflammation of the bronchial tube.

In answer to questions from Dr. Atkinson, Dr. Platt said the child was three years old; it had large deposits on the tonsils, and he thought the trouble commenced in larynx because the tubes relieved the troubles.

Dr. S. T. Earle thought the diptheritic membrane only showed itself in the pharynx, whilst that in the larynx was a cropous deposit.

Dr. I. E. Atkinson said for a long time he had been uncertain as to whether or not croup and diphtheria were distinct affections, but he had recently read Virchow, as showing the absolute differences between the affections. There are many conditions giving rise to exudations, thus the inhalation of steam will cause an exudation in the throat. What is called a diphtheritic exudation may not necessarily be produced by the disease diphtheria; we may have it with carbuncles as upon the intestines in certain affections. We will not get at the bottom until we know the etiology of the diseases. Any inflammation or stimulant that causes necrosis of the tissues may give rise to exudation; in one case it may be a simple, in another a specific stimulant. A purely croupous pneumonia differs from the true diphtheritic exudation in that in the latter the cause is persistent; in the former it soon ceases and the disease thus tends to self-limitation. In diphtheria we have a disease giving rise to deposits which do not tend to self-limitation.

Dr. S. T. Earle said in Dr. Platt's case the exudation was diphtheritic in the fauces but croupous in the larynx.

Dr. J. N. Mackenzie thought the fact of a diathetic condition in the production of a membrane a good one; the deposit was frequently met with in nares and upper part of pharynx.

Dr. W. B. Platt exhibited specimen of

CARIES OF THE CLAVICLE, STERNUM AND FIRST RIB IN A SYPHILITIC INDIVIDUAL, WHO DIED OF TUBERCULOSIS.

The patient was a mulatto, female, aged 32, single; has had two children, the last born dead, although at full term. No history of skin eruption or of syphilis obtainable. Although never vigorous she had no constant cough until seven months ago, but some cough every winter; no hæmoptyses. The patient presented the picture of advancing tuberculosis. At the upper border of the sternum is an opening discharging pus, and within which can be felt dead bone. This from its position is referred to the sternum, clavicle or first rib. The pus apparently communicates with the lung. Dulness, rales, bronchial and cavernous respiration heard over the upper fourth of both lungs. The diagnosis was made of syphilis and tuberculosis, with the origin of the caries probably syphilitic.

The autopsy held three months later showed caries of the upper part of sternum, inner end of the clavicle and of the first rib.

Extensive tubercular infiltration of both lungs at their upper portions, with small cavities. Tubercular inflammation of one kidney, the ureter on that side, and the bladder. Moreover, tubercular ulceration of both the small intestines and of the rectum, miliary tubercles of the spleen and amyloid degeneration of the liver. There was an erosion of the inner table of the parietal bone of the left side, which had perforated the skull. The latter lesion is tributed to syphilis, and is the only anatomical existence of the disease in the case. The diseased bones were then shown.

DELEGATES APPOINTED FROM THE CLINICAL SOCIETY OF MARYLAND TO THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, APRIL 3, 1885:

A. C. Abbott, A. K. Bond, H. H. Biedler, J. M. Craighill, W. T. Councilman, H. S. Castleman, W. F. Coleman, S. T. Earle, F. J. Flannery, George R. Graham, John G. Holliday, J. B. Hartz, C. Hampson Jones, W. E. Mosely, F. A. Morawetz, H. Louis Naylor, H. G. Prentis, J. E. Urquhart.

Delegates Appointed from the Clinical Society of Maryland to the American Medical Association, April 3, 1885: I. E. Atkinson, F. E. Chatard, Jr., O. J. Coskery, J. H. Hartman, Herbert Harlan, Thos. S. Latimer, John Morris, H. C. McSherry, F. T. Miles, A. C. Pole, Geo. H. Rohé, Alan P. Smith, J. E. Michael, Randolph Winslow, P. C. Williams, Richard H. Thomas, E. F. Cordell, J. F. Perkins.

Editorial.

Higher Medical Requirements in Virginia.—We rejoice with the profession in Virginia in the auspicious inauguration of a new era of medical practice in that state. After many years of tyranny from medical pretenders and quacks, the long sought relief has come, and a permanent benefit to the people and to the profession of that state has been secured. The law creating a State Board of Medical Examiners went into effect on January 1, 1885. In accordance with the requirements of this law the Board convened in Richmond on April 10th and examined a number of applicants for license to practice medicine in the state. From a full and satisfactory report of this meeting published in the *Virginia Medical Monthly*, for April, we learn the following facts. Of the thirty-two members composing the Board twenty-three were in attendance. The Board met in the Hall of the House of Delegates, and, after announcing the Committees to Examine on the different branches of the medical sciences, the examinations were begun.

The following brief plan of examinations was announced to those applying for a license to practice. "1. Examination questions and answers are to be in writing or printing. 2. The applicant is required to answer at least three-fourths of the questions satisfactorily, and show a fair, general knowledge of all the branches upon which he is examined. 3. Applicants can neither give nor receive information relating to the subjects under consideration during the examination. 4. No examiner is permitted to tell the applicant the result of his examination until after tho examinations are over and have been passed upon by the Board."

The questions presented to the candidates by the several committees were, for the most part, practical, and required a good general training upon the part of the candidates to answer them. Indeed we think the examination more rigid than that usually conducted by the medical schools of this country. The Board seemed to be dreadfully in earnest, and it has performed its duty in a manner worthy of commendation. We fully agree with the Board in the opinion that any candidate answering three-fourths of these questions satisfactorily is justly entitled, and is fairly prepared, to enter upon the practice of medicine. The examination seems to have been conducted in a fair and careful manner. The candidates were allowed ample time to prepare their examination papers. Those who failed to receive the license of the Board were evidently not worthy of it.

The result of the examination showed that twenty candidates had successfully answered the questions, and these received the license of the Board. All of the graduates of the medical schools of the state passed a successful examination, whilst only about 28 or 29 per cent. of the graduates of all the other medical institutions of the country were successful on the very same examination. This fact, says our contemporary, "speaks well for the standard of graduation of the two medical colleges in this state—the Medical Department of the University of Virginia and the Medical College of Virginia." "It need scarcely be said that such a result was altogether without the plan, intention or knowledge of the examiners—few of whom knew where any of the applicants graduated."

The names of the rejected applicants are withheld, as also the schools from which they graduated. Before any comparisons should be instituted in regard to the teaching qualities of the various outside institutions, whose graduates were turned down by Board, it would be proper to take into consideration numerous facts which might have had an influence in bringing about

the result. From the high character and reputation of the gentlemen composing the Board of Examiners, we feel confident that their work was conducted in a perfectly impartial manner, and we think this result should be accepted in this spirit by the institutions whose graduates were unable to reach the mark established by the Board. We fully agree with our contemporary that "the effects of results like that which has just occurred before the Virginia Board of Examiners will have a beneficial— a stimulating influence upon the Faculties of colleges outside of Virginia. Sooner or later other states will establish Board of Medical Examiners, and their questions will be of the same general practical value as those adopted by the Virginia Board."

Whilst then we rejoice with our professional brethren in the "Old Dominion" in the results recently secured which raise the medical requirement a niche higher in their state, we must turn the minds of our readers to the disconsolate condition of medical matters in our own state. Surrounded on all sides by states which enjoy the benefits of legal protection from ignorant and incompetent practitioners, our state and city are overrun with every species of humbuggery and quackery the ingenuity of man can devise.

Until some medical Moses is raised up to lead the profession of Maryland from this land of bondage, it is not probably that any progress will be made in the direction of securing the passage of the laws so much needed to regulate the practice of medicine in the state.

Prof. Newell Martin on the Zoophilist.—Prof. Newell Martin's castigation seems to have caused some panic in the office of the *Zoophilist*. Its editor hastened to circulate a reply, without waiting for his regular monthly issue. This reply is a curiosity. It ignores altogether most of the charges of deliberate falsehood brought by Prof. Martin, and reasserts one of them in slightly changed words. The original statement was that all the animals used in Prof. Martin's experiments were curarized and suffered great pain. The editor now says that he meant that the tracheotomised animals were all curarized. As tracheotomy was necessarily performed in every case, while curaré was given only in two instances, the newer statement of the *Zoophilist* is the same old lie in a different dress.

To the editor's reply is appended an anonymous letter signed "Onlooker." This person undertakes to prove that it is impossible to render unconscious by chloroform, ether, or similar agents a curarized animal. This extraordinary delusion seems widespread among the anti-vivisectors. The question as to how it arose is an interesting one, and we hope Onlooker will fulfil his promise.

Sir Andrew Clark on the Tubercle Bacillus.—It is sufficient evidence that the profession is not of one accord in regard to the bacillary origin of tubercle when we find so eminent an authority as Sir Andrew Clark, Bart., M. D., F. R. C. P., ranging himself with the opposition. This he does with a very decided tone in the second of his *Lumleian Lectures* on *Primitive Dry Pleurisies*, delivered recently before the Royal College of Physicians. Whilst granting that the causal agency of the bacillus is extremely plausible he declares that it is not proven, and that a greater number and variety of control-experiments are needed to satisfy his skepticism, and that there must be admitted the existence of bacillary and non-bacillary consolidations, and therefore of a bacillary and non-bacillary phthisis. As a reason for this opinion he adduces the fact that in several cases of phthisis ensuing upon fibroid disease of the lung he has failed to find the bacilli either in the lungs or in the expectoration. That this was not merely a result of a defective method of examination is shown by the success which the same method yields in tubercular cases. He adduces further the widely differing histories of the affections now ascribed to a common bacillary origin, and comments upon the difficulty of reconciling them with such exclusive origin merely by a difference of constitution and soil.

Diseases are now ranged under one name, which differ widely in their symptoms, duration, cause, effects and issues, not only in the same body but in the same organ.

Sir Andrew concludes his lecture rather apologetically with these words: " At the present time when men are still in the fervour of their conversion to the brilliant experimental discoveries of Koch, such pro-

testations of a sober judgment will be regarded as unpardonable sins and punished with suitable severity. Well, the sufferers under chastisement must console themselves with the reflection that it is only those whose judgments have been disturbed by emotion, or who have never sounded the deepest depths of knowledge, or who have not passed through the perils of its subtlest casuistries, that are exempt from difficulties, or doubts or fears; and that, for the most part, truth is won not only by those who rush impetuously forward in its pursuit but by those who with open and eager mind are yet in patience content 'to labour and to wait.'"

Home for Incurables of Baltimore City.—The First Annual Report of this Institution, which was incorporated November 15, 1883, lies before us. The purpose of its founders was "to provide in or near the city of Baltimore an asylum or home for persons afflicted with any incurable physical disability or disease who may be received into such home." A building was selected for temporary use at 270 E. Fayette street, furnished and opened with a donation party November 6, 1884. At the date of the report there were 7 inmates, with accommodations for 15, with a permanent building fund amounting to $14,728, and a current expense fund amounting to $993.86. At present only female inmates are admitted. In a few days a Kirmes will be given for the benefit of the permanent building fund, and doubtless a large sum will be realized.

Miscellany.

Emetics.—*Dr. C. J. Hare* read a paper on "Emetics; their present neglect in the Treatment of Disease; is it reasonable? is it right?" The subject of the communication was one of the numerous points referred to in a previous address on "Good Remedies out of Fashion." Although not a panacea, in certain cases emetics cured in a marvellously short time; and in others they also appeared capable of saving life. The author passed in review the various members of this group of drugs, and their doses. Speaking generally, ipecacuanha was the most useful, in doses of 20 to 25 grains of powder in water, or 6 to 8 drachms of the wine. Now and then purgation resulted instead of emesis; but persistent diarrhœa never set up. The chief value of emetics consisted in their mechanical action upon the viscera; the stomach was not only emptied, but its innumerable follicles were cleared by pressure, the lungs were compressed, and mucus forced out of the air-tubes, and the œsophagus, larynx and fauces were swept clean. Allusion was made to cases of recurrent vomiting, commonly termed "bilious sick headaches," although more justly to be called "stomach-aches in the head." The persistent vomitings were endeavors of nature to expel the slimy mucus of the gastric follicles and the morbid ferments which it contained. The desired result was often at once effected by an emetic. Many anomalous ailments, accompanied by loss of appetite, nausea, the non-enjoyment of life, ill-temper, etc., were due to a similar cause, and were similarly relieved. The removal of the ropy mucus was promoted by washing out the stomach by means of warm water which excited additional vomiting. Emetics were sometimes of signal service in severe bronchitis, and in capillary bronchitis; the fear of "exhaustion" being produced by emetics was almost confined to those who never administered one. Attacks of catarrhal croup might be cut short in children, by half a teaspoonful of antimonial wine; and in membranous croup expulsion of the tough exudation was sometimes effected. Emetics were useful in the early stages of continued fever, of scarlatina and of measles, and in some cases of whooping-cough. They were decidedly beneficial in the treatment of delirium tremens, and also in acute mania. By the same means the paroxysms of ague could be greatly modified, and either arrested or rendered more amenable to quinine. Drugs and diseases have much the same mutual relation as in former ages; and as emetics were then found useful so they would now be, if fashion did not prevent their employment.—*Proc. of Harveian Soc. of London, Brit. Med. Jour.*, March 21st.

The Injection of Hot or Cold Water in Uterine Hemorrhage.—Dr. Schwarz relates a case of post-partum hemorrhage which was controlled temporarily by an injection of water at a temperature of 120° F., containing two and a half per cent. of

carbolic acid. The bleeding began again, however, and could not be arrested by further hot-water injections. A trial was then made of ice-water with perfect success. In other puerperal and non-puerperal cases, after failure with hot water the author obtained most satisfactory results with cold injections. Dr. Graefe has also had several cases in which he found cold irrigations to answer the purpose after hot water had failed. He regards the styptic action of hot water as due not only to the swelling of the tissues which it causes, but also to a certain degree of muscular contraction in the uterine walls. The former is not sufficient in itself to arrest the hemorrhage unless aided by muscular contraction. When cold water irrigations follow those previously made with hot water strong contractions of the uterine muscle are excited, but the œdematous swelling caused by the hot water cannot be so rapidly overcome, and hence the two conditions most favorable for arresting the hemorrhage are present. In the same way, when hot injections follow cold ones, the irritation to the muscular tissue remains, and to it is added the swelling of the tissues above mentioned. If only one be used, Schwarz prefers the cold water, as having the advantage of absolute safety. Hot water, if too hot, may cause a paralysis of the uterine muscular tissue, and if not hot enough will only increase the hemorrhage. If a trial with one temperature be unsuccessful, the use of the opposite will almost certainly control the bleeding.—*Schmidt's Jahrbücher, No.* 7, 1884.—*Med. Record.*

Functional Disturbances of the Eyes following Diphtheria of the Fauces.—Herschel: (*Jahrb. f. Kinderh.* [from *Berl. Klin. Woch.* 1883], B. xxi., H. 4.)—The disturbances of vision which follow diphtheria, in so far as they depend upon paralyses of the motor portion of the optical apparatus, have been observed many times from the days of Donders, and a knowledge of them is a common thing. The author has been in a position, however, in cases in which the proof of pre-existing diphtheria was not always conclusive from other sources to discover disturbances of accommodation and a narrowing of the field of vision, which could only be referred to changes in the perceptive portion of the optic apparatus. Such a condition obtained in a girl, ten years of age, in whom asthenopic trouble had begun so that she was able to read with the left eye only Jaeger No. 11, and that with great difficulty. Ten days later she could read only No. 6, with both eyes, and soon afterwards the energy of accommodation became still more feeble. Further, the movements of a hand before her eyes fixed in straight-forward vision upward, downward, and sidewise, were not perceived. All evidences of irritation were wanting, and the retina appeared to be normal. Soon after this the power of accommodation improved and with it the field of vision became enlarged, so that in three and one-half weeks the condition was normal again. Twelve other cases which were examined with Foster's perimeter gave evidence of disturbance of accommodation of a diphtheritic character. Four of them showed concentric limitations of the field of vision, without susceptibility to dazzling illumination. In all cases the accommodation trouble was not exaggerated, there was no central scotoma, nor disturbance in the sense of color. The treatment which was recommended for the diphtheritic paresis of accommodation consisted in the use of a one-half per cent. solution of salicylate of physostigma by instillation once or twice a day. No curative influence can be expected from eserine. Among French writers preparations of belladonna are highly esteemed.—*Archives of Pediatrics.*

Gastritis Favosa: A New Disease.—At the meeting of the Vienna Imperial and Royal Society of Physicians on the 28th of November, Prof. Kundrat exhibited specimens of a unique kind. The case was one of favus universalis which had given rise to an abscess of the thigh, and had terminated fatally from severe gastro-intestinal disorder marked by an uncontrollable diarrhœa. Numerous erosions mingled with diphtheritic swellings were found in the mucous membrane of the stomach, and the intestines contained some foul putrescent masses and much mucus. Prof. Kundrat at once declared the diphtheritic swellings to be due to the favus fungus,—a view which was confirmed on microscopic examination. This is the first recorded instance in which the mucorineæ have been the cause of death, as it is the first of favus of the stomach and intestines. Indeed, the

naked-eye appearance of the tumors in the stomach closely resembled the favus cups on on the skin, and the fact that little of the fungus was found in the intestines was explained by Prof. Kaposi by their having undergone putrefaction in the bowel. The patient had previously been shown to the Society by Prof. Kaposi as a rare instance of favus which covered the entire body, affecting even his finger-nails (attributed to his habit of scratching himself constantly). Favus of the stomach is as unknown a condition in animals as it is in man; at any rate, Prof. Csoker, of the Vienna Hospital for Animals, stated that it never occurred in cats, although these animals frequently eat rats infected with the fungus. Prof. Bamberger suggested that in this case the gastric mucosa was in an unhealthy condition at the time of infection, thereby affording a favorable nidus for the growth of the fungus. It must be borne in mind that the mucorineæ, unlike the schizomycetes, can thrive in acid liquids, and may therefore grow with impunity in the stomach. The case is of great importance, as showing that, if they do gain access to the interior part of the body, these fungi may be a source of danger and lead to a fatal result thereby disproving the usually-accepted notion of their harmless character.—*Lancet.*

Salicylate of Sodium in the Treatment of Migraine.—Cutierrez (*Paris Med.*; *Lyon Med.*) recommends this drug very highly, fifteen grains being administered in two doses, with an interval of a quarter of an hour. He states that speedy relief is experienced after taking the first dose, and that when the second one is taken the pain vanishes completely.—*N. Y. Med. Journ.*

Erratum.—In the title of Dr. A. L. Hodgdon's paper, published in last issue, read "ingestion" instead of "injection," on page 475.

Spontaneous Dislocation of the Lens.—At a meeting of the Midland Medical Society, Nov. 9th (*British Med. Journal*), Mr. Priestley Smith, exhibited an interesting case of a boy, eight years old, with spontaneous dislocation of the crystalline lens into the anterior chamber. The lens was perfectly transparent and retained a partial attachment to the suspensory ligament. The condition was no doubt congenital, as a similar condition existed in both eyes. The diagnosis was made from the presence of a bright golden reflex surrounding the margin of the lens. This reflex is always present, as was first pointed out by Knapp. It is a rare condition, and often difficult to diagnose.

An Ophthalmic Antiseptic Solution.—In recent discussion at the Paris *Academie de Medicine* (*Union Med.*) M. Pans stated that, in a large practice in ophthalmal surgery, he had never had any cases of erysipelas after the use of the following mixture:

℞. Bichloride of mercury, Chloride of ammonium, āā 5 grains.
Glycerin, 3 drachms.
Water, 3 quarts.

The parts are washed with the solution, after the operation a piece of linen dipped in the fluid is applied to the affected eye.—*N. Y. Med. Journ.*

Precautions to be Adopted in the Treatment of Phthisis.—At the International Congress of Hygiene held at La Haye in September last, the following conclusions were adopted regarding the treatment of phthisical patients, after an interesting discussion upon a report presented by Prof. Sormani, of Pavia.

"It is demonstrated that pulmonary phthisis can be, in certain cases, transmitted from the sick to individuals in health. Although the chances of this transmission are limited, prudence requires certain precautions.

"1. No one should be allowed to share the sleeping-chamber or bed of a tubercular patient in an advanced stage of the disease. The apartment of a phthisical individual should be constantly aired and ventilated.

"2. The danger resides especially in the sputa, which should not be allowed to go on the floor or on clothing, where they may dry and become converted into dust.

"3. The sleeping-rooms, the bed-linen, and clothing which have been used by consumptives should always be disinfected. Steam (at 100 deg. C.) and washing in boiling water are the best means of disinfection.

"4. Convalescents from chest-disorders and feeble and exhausted patients should especially avoid prolonged contact with the tuberculous."—*Revue de Therapeutique Med.-Chir.*, No. 23.

Medical Items.

It is proposed to establish a hospital at Port Said, in Egypt, in memory of the English hero who devoted his life to that unhappy country. It is a good idea, and one that will meet with universal approval. The *Lancet* very aptly remarks in regard to this scheme: "It will be well if we are permitted to leave this one trace of benevolence in the region where we have left so many memories which posterity will view with less complacency."—*N. Y. Med. Jour.*

The third annual commencement of the Woman's Medical College of Baltimore will be held at Lehman's Hall, in this city, on May 1st, at 12 M. The address to the graduating class will be delivered by Prof. J. Edwin Michael, of this city.

The Detroit Lancet says: Cincinnati made about twenty-eight and one-half million gallons of beer last year, and consumed over eighteen millions of gallons. Each man, woman and baby on the average must drank two barrels of beer. Such are some of the statistics presented by the superintendent of commerce of Cincinnati. Evidently Cincinnati grows rich by drinking its own beer. Of course beer simply whets the appetite for stronger drinks, whiskey, etc.

Mr. Lawson Tait says: "The amount of worry which is given him by every case of hysterectomy, even when successful, is such as to be almost beyond the recompense of any fee; and the disappointment inflicted by every death is quite indescribable.—*Exchange.*

Dr. Edward T. Ely, a promising young physician of New York City, died on April 12th. He was associated in practice with Dr. D. B. St. John Roosa, and stood high as an oculist, having contributed a number of important papers in this branch.

Sir James Paget was recently elected corresponding member of the Academie des Sciences.

The American Neurological Association will hold its eleventh annual meeting in New York City on June 17, 18 and 19.

A bill has been introduced into the State Legislature of Massachusetts incorporating the "New England Cremation Society."

The American Journal of Neurology and Psychiatry has recently been discontinued.

Our esteemed contemporary, the *Virginia Medical Monthly*, begins volume XII, No. 1, for April, with a new outfit of spring clothing. The appearance of the journal is much improved by the adoption of a tinted paper of a rich color. In fact, the *Monthly* shows many evidences of the prosperity its able and energetic editor deserves for his work in behalf of American periodical medical literature.

The Medical Association of the District of Columbia elected officers for the ensuing year, on the 6th inst., as follows: President, Dr. D. C. Patterson; vice-presidents, Drs. A. F. A. King and J. O. Stanton; secretary Dr. Lachlan Tyler; treasurer, Dr. S. S. Adams; board of counsellors, Drs. J. W. Bulkley, J. W. Lovejoy, W. H. Taylor, J. T. Johnson, C. W. Franzoni, C. E. Hagner, E. C. Morgan, J. F. Thompson and G. B. Harrison; board of censors, Drs. T.C. Smith, W. C. Briscoe and J. H. Mundell.

The continued improvement in General Grant's condition has excited a number of critical comments from the secular press. As is usual in such cases the medical attendants are the targets aimed at. The question of "diagnosis" and "prognosis" is being learnedly discussed by the reporters, who appear to be better informed in regard to the distinguished patient's condition than his medical attendants.

Official List of Changes in the Stations and Duties of Officers Serving in the Medical Department, U. S. Army, from April 14, 1885, to April 20, 1885.

McParlin, T. A., Lieutenant-Colonel and Assistant Medical Paymaster, U. S. Army, sick leave extended three months on surgeon's certificate of disability.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service for the week ending April 18, 1885.

Yemans, H. W., Assistant Surgeon, detailed as medical officer, revenue steamer "Corwin" during cruise. April 16, 1885.

Battle, K. P., Assistant Surgeon, when relieved to proceed to New Orleans, La., for duty, April 13, 1885.

Brooks, S. D., Assistant Surgeon, granted leave of absence for ten days. April 16, 1885.